EXHIBIT "M" - Mahoney Deposition

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF MISSISSIPPI

JACKSON DIVISION

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JOSEPH PAPIN,

Plaintiff,

v.

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER; DR. LOUANN WOODWARD, in her official capacity; and DR. T. MARK EARL, in his individual capacity,

Defendants.

CASE NO.: 3:17-CV-763-CWR-FKB

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Videoconference Deposition of

MEAGAN MAHONEY, MD, taken

on November 18, 2020, commencing

at approximately 1:59 p.m.

A P P E A R A N C E S

ALL APPEARANCES BY VIDEOCONFERENCE

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I N D E X

DEPOSITION OF MEAGAN MAHONEY, MD - 11/18/2020

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(THIS DEPOSITION WAS TAKEN PURSUANT TO THE FEDERAL RULES OF CIVIL PROCEDURE. READING AND SIGNING BY THE WITNESS IS RESERVED.)

MEAGAN MAHONEY, MD

was sworn and testified as follows:

THE WITNESS: I do.

EXAMINATION

BY MR. MORGAN:

Q. Dr. Mahoney, if you could, state your full name for the record, please.

A. Meagan Elizabeth Mahoney.

Q. And where do you currently live, Dr. Mahoney?

A. In Columbus, Georgia.

Q. How long have you lived there, ballpark?

A. About two years.

Q. We met a moment ago. My name is Ryan Morgan. I represent Dr. Papin in a case he has brought against UMMC related to certain violations he is alleging.

Have you ever had your deposition taken before?

A. For this case or for anything?

Q. For anything.

A. I think we had a meeting in 2017 regarding this, but that was it.

Q. Okay. So that was the appeals hearing when you provided some testimony?

A. Yes.

Q. Okay. Other than that, have you ever had to provide any sort of sworn testimony like this?

A. No, sir.

Q. Whether it's in a deposition -- it's kind of a new thing here now doing all this by Zoom. It used to always be in person; right? But now it's by Zoom or testifying in court. Never had to do anything like that?

A. No, I have not.

Q. That's totally fine and very normal. But I'm sure Tommy has sort of given you a few, quote, "ground rules" that lawyers always like to recite at the beginning of depositions. But, you know, just to be sure, we do have a court reporter typing everything down. So we want to be very careful with how we communicate with each other. I'll ask questions, and then you'll answer. You're going to know halfway through my question what I'm sort of asking, but just let me finish it. That way the court reporter can type it down perfectly clearly. And then the same

thing for me. I'm always ready to jump in and ask you a followup question. But I have to be good about letting you finish your answer, too.

It may be a little obvious, but just for the record, uh-huhs, huh-uhs don't show up real well on the transcript, so I'll just prod you for a yes or no just to be sure we know what your answer is. Okay?

A. Okay.

Q. If I ask a question that just does not make sense or it's confusing for whatever reason, please ask me to rephrase it. It does not offend me at all. You know, you're a medical expert. I'm not. So if I say something that just doesn't seem right, please don't hesitate to ask that. Okay?

A. Okay.

Q. And if you need a break at any point, let me know. I typically will try to take a break about every hour, whenever we need one. It sounds long, but trust me, the time goes faster than you think.

A. Okay.

Q. Now, I have to ask this of each person, so I do apologize in advance. Have you ever been convicted of a crime?

A. No.

Q. Are you on any sort of medication, drugs or

anything that would affect your ability to remember facts from years ago?

A. No.

Q. Okay. For this deposition I'm going to ask you some questions about how you prepared for it. I don't want to know any sort of substance of a conversation you had with Mr. Whitfield. But I would assume you did speak with Mr. Whitfield regarding this deposition; is that correct?

A. Yes.

Q. How many times did you guys talk to prepare for this deposition?

A. Twice.

Q. When was the first time?

A. Last week. I'm not sure of the day. And then earlier today.

Q. Last week, ballpark, how long did that conversation last?

A. About an hour and a half.

Q. What about the one this morning?

A. 20 minutes.

Q. How did you first find out that you were going to be sitting for this deposition in this case?

A. I believe Tommy emailed me, first reached out through email.

Q. Okay. Did you review any medical records in preparation for this deposition?
A. I did.
Q. Which medical records did you review?
A. I looked at the wound care note from the patient, Joe Papin's daily progress note, a couple of daily progress notes, and then the operative note on the patient in question with the sacral decubitus wound.
Q. Okay. Any other records that you reviewed?
A. I looked at text messages and my previous report in that meeting in 2017.
Q. Okay. Anything else?
A. I believe that's all.
Q. Okay. So the medical records for the ulcer patient, we'll talk about that person as well. And then text messages. Those are the two types of documents you looked at?
A. Uh-huh (positive response).
Q. Is that a yes?
A. Yes. Sorry.
Q. It happens every time.
A. Yeah.
Q. I know you testified you've been in Columbus about two years. Are you married?

A. Yes.
Q. How long have you been married?
A. Four or five years. Five years.
Q. Do you have any children?
A. Yes.
Q. How many kids?
A. One.
Q. How old are they?
A. Nine months old.
Q. Oh, man. Hopefully sleeping.
A. Not really.
Q. I have a nine and a four-year-old. I've been there. Luckily mine weren't terrible.

But if you could, walk us through your education background, kind of starting with high school, where you graduated, and up through your most recent schooling.

A. I went to Columbus High School in Columbus, Mississippi, graduated in 2003. Went to Mississippi State University, majored in biochemistry and molecular biology, graduated in 2007. I took a gap year and then went to medical school at the University of Mississippi in Jackson, Mississippi, graduated in 2012. Started general surgery residency after graduation, did a fellowship in critical care,

surgical critical care in 2015 to 2016. And then came back to finish my fourth and fifth year of general surgery residency and graduated in 2018.

Q. Okay. The fellowship, was that at UMMC, too?

A. Yes.

Q. So I guess what years were you then at UMMC, ballpark?

A. So 2008 started medical school and then 2018 finished residency.

Q. And then is that when you got the position where you are now in Columbus, Georgia?

A. Yes. We moved about October -- I started October 1st, 2018.

Q. Okay. And which hospital do you work for?

A. Piedmont Midtown.

Q. And that is Columbus, Georgia; right? Not Mississippi?

A. Right, yes.

Q. Do you remember Dr. Papin?

A. I do.

Q. When did you approximately work with Dr. Papin time frame-wise?

A. I believe it was when I came back from my fellowship. So 2016, July 2016-2017.

Q. And I think at that point in time you were considered a chief resident; is that accurate?
A. I was a fourth-year, so I was chief on certain services. A true chief is a fifth-year resident.
Q. If you could explain to me what you mean by being a chief on certain services?
A. A chief on a service just means that you're the highest level of resident for that service.
Q. And for the record, when you say "a service," I'm just trying to make sure we're on the same page. What do you mean by "a service"?
A. A service being like trauma surgery service, general surgery service, thoracic surgery service. Different types of surgery.
Q. To explain, I understand that some of my questions may seem basic. But there's a chance that the transcript could be read to a judge or a jury one day.
A. Sure.
Q. So I might have to ask those questions just to make sure laypersons can understand what's going on.
A. I understand.
Q. So when you were that fourth year and you

were the chief for one of those services, what were your job duties and responsibilities in a nutshell?

A. While continuing our basic general surgery training, we're also overseeing the residents below us, taking trauma call approximately two weekends a month. And then when we're on call for trauma, we also have to field general surgery consults.

Q. Okay. What about the responsibilities in regards to other lower residents than you, first, second, third years?

A. We're supposed to help with their training as well, kind of teach them in the operating room. If we notice that they're having any difficulties with their time efficiency, we're supposed to help them with that. And then overall monitoring of the patient care on our service.

Q. Is it different for a first-year resident versus a third-year resident?

A. Yes.

Q. In what way?

A. First-year residents are usually mostly on the floor, meaning they're in the patient wards. They're doing a lot of the notes, a lot of the patient orders, carrying out the responsibilities of calling consults, following up on the consult recommendations.

And they are generally the first line for the patients. The patients usually see them more than they see anybody on the team.

Q. When you say "the team," can you kind of describe to me who would be "the team"? What type of positions are part of the team?

A. The team usually consists of -- depending on the service, what service -- the trauma service in particular, we have a chief resident, a middle level usually, which would be a third year, and then two interns.

Q. You're saying "intern." Does that mean the first-year resident?

A. First-year resident.

Q. And when you say a chief resident, would that be you as a fourth-year chief of the service or are we talking an actual fifth-year chief resident?

A. For trauma surgery, the fourth year was the chief of that service.

Q. What about the attending physician? Are they part of the same team or no?

A. They are. The residents are on the team for usually a month at a time together. The attendings -- we have several attendings that rotate weekly. So we would get one attending per week, and then they would

rotate to either acute care or ICU or research week, and then we get another one.

Q. And when you say "interns," when you're using that term, can I just assume that means just a first year?

A. Just a first year.

Q. So second year, you would no longer call them an intern?

A. Correct.

Q. When you are -- let me back up.

Did you work with Dr. Papin the whole time during this kind of -- we'll call it the latter half of 2016 into '17? Or was it different months based upon the rotations?

A. I don't know if we worked together any other months. I would assume that we did some calls together on the weekends because you're put randomly twice a month for 12 months. But we were together on the trauma service that December 2017.

Q. Is that when you specifically remember, but you can't remember any other assignments where you were on the same service?

A. No.

Q. If you could, just explain briefly when you say "the trauma service," what does that mean?

A. The trauma service is trauma patients. We're a level 1 trauma center in Jackson. Anything from car wrecks to gunshot wounds, knife stabbings, whatever, would come in through the ER. They would be evaluated by the trauma team and then, if deemed admission, they would come onto the trauma service where the trauma team would round on them daily.

Q. Okay. So then during that month, that December 2016 trauma service month, were you just overseeing the third-year resident and then two interns?

A. Yes. That was the team. I was the chief of that. So yes.

Q. Okay. I didn't know if you had other teams that you would be a part of or just that one.

A. No. Just the trauma team.

Q. And then, theoretically, the following month, whenever you'd rotate to a new service, you'd be part of a different team then?

A. Correct.

Q. What was your regular schedule like, if you can recall, during that December 16 trauma service?

A. I don't recall specifics. But typically things ran the same way every month. The interns would see the floor patients; the mid level, whether

it's second or third year, would see the ICU patients; and then we would all meet together -- they would all meet with me. What we do is called "run the list" where we talk about every patient, and I get their take on new labs for the day, physical exam, anything -- any plans that are going on. And then we would then round with the attending when the attending was ready. Then the residents -- the lower-level residents would carry out the plans for the day, and I would either help them or be in the operating room. And then at the afternoon session, usually right before we signed out to the night team, we would meet again to run over the list again just to see if there was any new developments throughout the day.

Q. Okay.

A. And also we would -- any new trauma patients that came in to the ER we would have to evaluate if we were called during the day.

Q. Is this Monday through Friday or seven days a week? How often are you doing this?

A. For the trauma team that we're talking about, it would be Monday through Friday, yes. And then whoever is on call for the weekend would do essentially that same thing on Saturday and Sunday.

Q. So like for this, the ulcer patient that

we'll talk about in a little bit, is it fair to say that that person was in the hospital for quite some time, weeks?

A. I don't remember the exact dates, but yes.

Q. And so theoretically then you would have been discussing that patient every day when you were running the list in the morning?

A. We should be, yes.

Q. And maybe again in the afternoon depending upon if something came up?

A. Yes.

Q. Now, if nothing comes up for a patient, do you just kind of skip over them real quick? Or how does it work in practice?

A. Usually we just say "nothing new."

Q. So if it's like John Smith, you'd say: Nothing new since this morning, go to the next one?

A. Right.

Q. Is it fair to say that the afternoon running the list probably is shorter than the morning one?

A. It is.

Q. Now, what sort of authority did you have over an intern when you were the chief resident on a service?

A. Within the hierarchy of the residency

program, we're considered in charge of them. Every year is considered ahead of the level below them. So an intern has to answer to a second, third, fourth, fifth year. Second year has to answer -- you know, and so on.

Q. Do you remember during December 2016 who the other members of the team were, the mid year or the other intern?

A. I don't remember the mid year, but the other intern was Will Brooks (sic). He was a urology resident.

Q. Okay. Do you remember if the mid year was a second or a third year during that time frame?

A. I can't remember. And sometimes we had the military -- had military residents from the coast. It may have been a military resident.

Q. So for like the regular -- let me start over.

For Monday through Friday during that December 2016 time frame, what time are you normally coming into the hospital?

A. I don't remember exact times, but I had to be there by 7 a.m.

Q. And is it a 12-hour shift? What's the typical sort of end time?

A. Every day except for Wednesday is -- we are on the clock from 7 a.m. to 5 p.m. And that's when the night team comes in. On Wednesdays it would be 7 a.m. to 7 p.m. because we have our educational conferences that day.

Q. And who would attend the educational conferences on those Wednesdays?

A. All the residents and some attendings.

Q. So did it matter what year residents you were or just all of them?

A. All of them.

Q. And who would be on the night team?

A. The night team consisted of four residents. It was called the "night float team." And that would be an intern, second year, third year, and fourth year, and then the attending.

Q. Is it sort of -- and pardon me for my ignorance of how it works. But is it sort of two equivalent teams, just one is day and one is night?

A. It's not equivalent. Every surgery service -- and I believe at the time we had nine surgery services. So every team during the day was assigned to a specific surgery service. You take care of the patients, do anything that needs to be done for patient care, and then you sign out to the night float

team, which is only four residents. And then they split up those nine surgery services amongst really the three of them. And then the chief was in charge of making sure everything kind of ran smoothly. And then they would also have to -- while covering those services, they would also have to see new patients and then the consults.

Q. Okay. What is the first memory you have when you first met Dr. Papin?

A. I really can't recall.

Q. Do you remember if on the first day of his residency if you told him that you were going to have problems with him?

A. No, I don't recall.

MR. MORGAN: Let's go off the record for one second here.

(A DISCUSSION WAS HELD OFF THE RECORD.)

MR. MORGAN: We're going to mark this first exhibit as Exhibit 1 here.

(EXHIBIT 1 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. Dr. Mahoney, do you see this on your screen?

A. Yes.

Q. This is an email from you to Dr. Earl and

Renee Greene on January the 10th of 2017. Do you remember this email?

A. Yes.

Q. Why did you write this email?

A. After we found out everything about the sacral decubitus wound, I had concerns about what had happened. My biggest concern was I felt that Joe had lied to me. So I went to Dr. Earl and Renee. And if I remember correctly, they told me to write it down in an email just so I had it all on paper. So I composed this email and sent it to them.

Q. Do you remember when you spoke to Dr. Earl or Renee about this?

A. It would have been after the holidays, so beginning of January.

Q. Okay. Because this was sent on January 10th. I didn't know if you had a memory -- if you talked to them maybe the day before that and said, okay, I'm going to send it tomorrow or something.

A. It would have been probably that Monday or Tuesday, but I don't recall the exact date.

Q. And did you speak to both of them together or were these separate conversations?

A. I don't remember.

Q. Do you remember anything else about the

conversations other than them saying to put it in writing?

A. No, I don't.

Q. Did they make any comment about Dr. Papin themselves?

A. No, not that I recall.

Q. And so this note -- I believe you said this, but correct me if I'm wrong -- this note was really spurred from your concern with the decubitus ulcer patient?

A. Yes.

Q. And I believe you said because you felt that Joe had lied to you about that patient?

A. Yes.

Q. What specifically do you think he lied to you about?

A. I felt that he had lied about his own exam of the patient. Going into some detail, I was in the -- when I was in the ICU during my fellowship, we had patients that would require laying in bed for long periods of time and would develop wounds on their back. And it can be very bad, very morbid for the patient. So I wanted the residents to look at the backsides once weekly just to make sure that there was nothing there that I needed to know about that we

could address. And I had asked every -- I guess for two weeks I had asked both Will and Joe about certain patients that may have been there for longer periods of time. And Joe had said that this patient did not have any wounds on their back.

Q. What did Will say about the patient?

A. Just no, there was nothing there.

Q. So Will also said no, there was nothing there?

A. Oh, no. Will wasn't seeing this particular patient that I remember.

Q. When you say you instructed them to look at the backside, is that a verbal instruction or is that in writing anywhere?

A. I sent emails at the beginning of most rotations. I don't know if I sent one. I don't remember. But it definitely was a verbal.

Q. When you would talk to and verbally give this to the residents, what did you mean when you would say "check their backsides"? Did you expand on that to them or was it just simply "check their backside"?

A. Turn them over, get the nurses to help you turn them over if you can't get them over. Because usually it takes more than one person. We have med

students on our service as well, so usually the med students would be helping. And then look at the backside for any wounds.

Q. And if you see a wound, what do you do?

A. Let me know about it.

Q. But is there a certain level of wound?

A. I told them -- because you never can tell what people's experience is. So I said -- typically what I would tell them is if you see even just a red skin tear or a huge gaping hole, let me know and anything in between.

Q. So it could have been like the most minor of minor abrasions you would want to know?

A. Yes.

Q. So your testimony then is that for kind of the first half of this December time frame, Joe did not tell you there was a wound?

A. Correct.

Q. Did you review the patient's chart during this beginning of December time frame?

A. Not during the beginning, no.

Q. Why not?

A. We have -- the trauma service is very large. So I did not have the time to go through every patient's chart unless there was a concern from the

resident or that I got a call from one of the nurses. In that case I would go into the patient's chart and look at details. But otherwise I relied on what the interns were telling me.

Q. So this patient would have come up several times during your running-the-list meetings?

A. Yes.

Q. And do you remember at any time during those running-the-list meetings Joe mentioning the wound care team had seen this patient?

A. No, I don't -- he did not.

Q. Do you remember anything at all about this particular patient during the running-the-list meetings?

A. Because of what happened afterwards, it stuck in my mind. Because on Mondays when we would meet together before rounding with the attending, I would say: Does this person -- did you turn this person over, do they have a wound? And he would say no.

Q. Would he say he turned them over, just no wound?

A. He would just say no wound.

Q. Do you have a specific memory of that or is that just what you believe?

A. No. I remember. Because we were standing outside the patients' rooms. And, you know, it sticks in my mind because of what happened to this patient and the wound that I saw.

Q. After you sent this January 10th email, Exhibit 1 here, what was the next discussion you had regarding Dr. Papin with either Dr. Earl or Renee Greene?

A. I don't remember. I don't remember what was said. I just remember that Dr. Earl became more involved and was going to have discussions. And honestly, my next memory of anything occurring is that 2017 appeals meeting.

Q. Okay. So as we're sitting here today, you remember this email. But then it's sort of -- I won't say a blank but unclear memories until the actual appeal hearing?

A. Correct.

Q. Do you remember at one point you gave Joe a numbering system for his behavior?

A. Yes.

Q. If you could, explain what is that numbering system?

A. From the beginning of the month Joe had certain characteristics. And I can't remember them

all. But I felt like I was having to repeatedly say something to him about his behavior. And I got to the point where, rather than having to say something to him every time, I said: Look, we're going to come up with a numbering system. That way I don't have to say anything to you in front of people. Because every once in a while -- you know, we couldn't leave the room because we were in a trauma situation. And if Joe wasn't listening to something I said, then I wanted to be able to let him know that he was exhibiting that behavior without having to call him out in front of people. So we created a numbering system. 1 was this, 2 was this. I don't remember the exact characteristics or behaviors. But if he was doing something, I would say: Joe, number 1.

Q. Understanding you may not remember which number was what, do you remember what any of the characteristics were that were numbered?

A. Only because I've reviewed some of the paperwork for this. One of them was like: Don't be a douche.

Q. And what do you mean by that?

A. He would get an attitude with people, even me sometimes. And you just can't have that when you're on a team.

Q. Do you remember any other ones besides being a douche?
A. Not really, no. It's been so long.
Q. I'm going to show you -- is your phone number 662-386-1027?
A. Yes.
Q. Is it fair to say you and Joe would text during the day?
A. Yes. I'd text with every member of the team.
Q. Right, yeah. It seems like that's kind of a common way to communicate about patients and just things going on; is that fair to say?
A. Right, yes.
Q. I'm going to share here -- we'll mark this as Exhibit Number 2.
(EXHIBIT 2 WAS MARKED
FOR IDENTIFICATION.)
BY MR. MORGAN:
Q. This looks like a text message between you and Joe. And I'll give you a second to just read it. But my question is going to center here -- it looks like in response to his -- and you can see my mouse moving; correct? (Indicating.)
A. Yes.

Q. In response to this text message here, it looks like you responded with "number 5." Do you see that?
A. Yes.
Q. That would have been a use of your numbering system to respond to certain behaviors?
A. Yes.
Q. Having looked at this, does this help refresh your memory at all of what number 5 would have been?
A. No. I mean I can make an assumption now based on reading it, but I don't know what it was back then in 2016.
Q. I don't want you to guess. But if you've got an educated guess, then certainly you can assert it.
A. My educated guess would be arrogance.
Q. Do you think that was one of the five?
A. It could have been, yes.
Q. Was lying one of them?
A. I don't recall. I think lying was mentioned in one of the documents that Tommy provided to me.
Q. But you don't remember yourself if lying was one of the numbers?
A. Not at this point, no. I just have to go

based on those documents.

Q. Do you think it would have been one of those numbers back then? That seems like a pretty serious behavioral trait.

A. It could have been, yes.

Q. You would agree with me there's a difference between being arrogant and then flat-out lying about something?

A. Yes.

Q. One is, I would imagine, much worse than the other?

A. Yes. Lying is much worse.

Q. In almost any profession, if you are a liar, you're going to get in trouble.

A. Yes.

Q. I mean if he lied to you, instead of you responding with a number, wouldn't you have said: Hey, you're in trouble for lying to me?

A. Yes, it should be.

Q. But other than the ulcer patient, there's nothing else that you can point to that you know where Joe lied to you?

A. Retrospectively, after the decubitus wound happened -- I can't remember specific examples. But when I looked back at our time over the course of the

month, I felt that he had been dishonest about different things. But I could not prove it, no.

Q. When you say "different things," do you mean in regard to this wound patient or something different?

A. Just in general, patient care, any patient, you know, whether it would be a lab value or doing something that I had told him to do and he didn't do it.

Q. And did you investigate and look into those allegations where you thought he was being untruthful?

A. No.

Q. It was just a general feeling you had?

A. Yes.

Q. Did you tell anybody about that general feeling?

A. I don't remember.

I would like to explain that with lying, interns particularly, it's a new world they're entering. There's a lot of education going on. There are times when an intern, even unfortunately upper-level residents, are caught in lies. You know, was their potassium okay today? And they say yes even though they didn't look at it because they're scared that they're giving the wrong answer. So whenever I

would recognize that -- if lying was a number for him, it would have been that I felt he was being dishonest about things -- which you could kind of tell just as you got up the scale in residency. And it was just something you would talk to the resident about. You know, I would rather you tell me that you don't know or that you didn't look than lie about it and say that it was okay.

Q. So there's been other times where other residents have told untruthful statements, and it's something that happens enough that you know to expect it and to try to correct it?

A. Correct. And it's usually minor things. But, you know they're scared that they've missed some things, so they don't give an honest answer.

Q. Why did you decide to use this number system?

A. Because I felt that I was -- from what I remember, I felt that we were having to have some sort of discussion or I was having to reprimand him several times a week, if not daily. And like I said, sometimes we would be in a trauma situation where we were in the trauma bay and could not leave the room to discuss privately, so I wanted to be able to say a number and he know what I was talking about even if

people were around.
Q. Wouldn't other people hear those numbers and think that was a little odd as well?
A. Probably, yes.
Q. But you felt it was better than completely reprimanding him in front of others?
A. Yes.
Q. Do you remember when in Joe's tenure you devised this numbering system?
A. I don't recall, no.
Q. Was it before the December 2016 trauma service?
A. It had to have been during that month. I'm not sure exactly what point we came up with it, though.
Q. Earlier I asked you about, you know, if you had ever -- do you remember ever telling Joe "am I going to have a problem with you" at any point in time?
A. I don't recall that, saying that specifically. It may have been in one of the documents. But no, I don't recall saying that to him.
Q. Could it have been during that first week of the trauma service?
A. It could have been, but I don't remember.

Q. You don't have an actual memory of saying that?
A. No.
Q. Did you ever do this numbering system for anybody else?
A. No.
Q. If you had to reprimand other residents, would you do it in front of others? Or how would you do it?
A. If it was a situation where, you know, right in the moment they needed to be told to stop doing something, then yes, I would do it in front of other people. I tried to always do it in private, but there were times where I would do it in front of people, yes.
Q. Do you recall the situation where Joe had asked to go for a run?
A. I remember the second time he asked to go for a run.
MR. MORGAN: I'm going to mark as Exhibit Number 3 here --
THE WITNESS: Let me turn my phone off. I'm sorry. I thought I had silenced it.
MR. MORGAN: That's okay.
(EXHIBIT 3 WAS MARKED

FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. And this looks like -- this is an email -- text message between you and Joe from December 6 where it looks like he was asking you to go for a run and you responded, quote, "as long as pagers work." Do you see that?

A. Yes.

Q. So in this situation you allowed him and were okay with him going for a run?

A. Yes, apparently.

Q. When you say "apparently," what do you mean?

A. That I was okay with him going that day. I didn't tell him no.

Q. Is that something other residents and doctors do occasionally?

A. No.

Q. Never?

A. Never. Occasionally, you know, somebody needs to run an errand, something, and they'll let us know and we cover for each other. But something as minor or personal as just going for a run is not done.

Q. So have you ever heard of any other resident or physician or anybody else at UMMC ever asking for permission or exercising during the day?

A. Not during the day. Not during their shift, no.

Q. I'll show you what we're going to mark as Exhibit 4. This is the second text message, December 15, between you and Dr. Papin. Do you see this?

A. Yes.

(EXHIBIT 4 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. And in this one it looks like -- I'll let you read it -- but you rejected his request to go for a run?

A. Yes. And I remember this day very well.

Q. What do you remember about it?

A. I had been in the operating room with a trauma patient. And then I got the -- when I got out of the OR, I remember seeing the text. And it seemed very unprofessional. I do remember that Joe was first call that day. So I didn't feel it was appropriate for him to leave the hospital when he was the first call for the trauma service, meaning that if the patient coded on the floor or their heart stopped beating, he would be the first one notified.

Q. Now, do you know if on that same day we were looking at, did Joe actually go for a run?

A. He said he did not. I do not know.
Q. Do you have any reason to doubt him?
A. Well, I don't -- at the time, you know, based on my memories of him, I would not trust him, no.
Q. But did you trust him at the time?
A. At that time I would trust him not to lie to me, yes, about something -- about leaving the hospital.
Q. Now, you testified earlier that you recall the appeals hearing regarding Dr. Papin; correct?
A. Yes. I remember being there and speaking.
Q. Okay. I'm going to share this. This will be --
A. I'd like to add -- may I add on that text message the other reason I was upset was because I had been in the operating room; he knew I was in the operating room. And when your chief resident is, you know, not available for emergency situations, it's good to have all hands on deck. So I don't know the timing of that first text. I obviously -- you know, I'm guessing I was not in the operating room. But that was another thing that frustrated me, was that his chief was not able, so he really needed to stay there to be a part of the team.

Q. Okay. Because you were in there dealing with an emergency situation, you felt it was especially not a good time to be requesting something like that?

A. Right, yes.

Q. I'm going to show you -- this is the appeal transcript. This was on July 18th, 2017. Does that seem about the right time frame to you, if you recall?

A. Yes. A lot of this kind of runs together.

Q. And I'm going to page -- this is page 50 of this transcript.

Now, did you attend this proceeding in person or were you by phone?

A. I was in person.

Q. Where was it held?

A. In one of the conference rooms at the University Medical Center.

Q. In this transcript here, I'm getting to the point where you talked about the exercising. There was a question where you talk about here -- do you see where it says, your second text message, about: "Hey, are you joking?" Do you remember that?

A. Uh-huh (positive response).

Q. That was when you had rejected him to go running; correct?

A. Well, I was more surprised -- I didn't feel like he had really asked me if he was going. So I was surprised by his text of saying I'm going to go running.

Q. And then you were asked a question later here about: "Was that the first time you and Dr. Papin had ever discussed exercise or leaving to exercise?"

And your answer was: "To my remembrance, yes."

Do you see that?

A. Yes.

Q. Is it fair to say, though, that that's not true because you had actually texted about it the week before on December the 6th?

A. Right. That was incorrect on my part.

Q. I'm sorry?

A. That was incorrect on my part. I did not remember that first text.

Q. Okay. Before the hearing did you go back and review text messages or medical records or anything like that?

A. I don't remember.

Q. You don't remember if you did or you don't think you did?

A. I don't remember if I did. I know I had some text messages from him, but I don't remember before this particular meeting if I reviewed anything.

Q. Did anybody ask you to review anything before the meeting?

A. No.

Q. Sorry. I'm just going through my outline here, making sure I'm covering all the things.

I want to go back to Exhibit Number 1 here. And I'm looking in particular at about -- well, I'm not going to say paragraph 2 but where it talks about number 2 here. Do you see that?

A. Yes.

Q. And this was about the time where there was a code that was called for one of Joe's patients. Do you recall that matter?

A. I don't recall specifics of the incident. I remember that it happened. But I don't remember specifics.

Q. What do you remember about it?

A. I only remember what I've read from the text messages and from this email. But Joe had sent me a text asking me for another chief resident's phone number, and I gave it to him. And I asked, you know: What's going on? Is it something to do with trauma?

And then he told me that he had, I guess, an inappropriate conversation -- the night intern had been rude and inappropriate with him, he felt. And I really don't have much recall of anything else.

Q. Let me see if I can make it a little smaller here. There we go. Is that a little better?

A. Yes.

Q. Is this the text you were just talking about?

A. Yes, it is.

Q. Okay. So the gray part on the left here is Joe responding back to you?

A. Uh-huh (positive response).

Q. Is that a yes?

A. Yes.

Q. So he sent this to you almost around the same time that this was occurring. I mean it looks like it was sent at 6:49. So we're talking less than an hour after the situation; correct?

A. Right.

(EXHIBIT 5 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. And then your response to it was just: "Okay." Is that accurate?

A. Yes.
Q. After this incident occurred did you go talk to Joe about this? Was it a big deal at this time on this date or the next day when you saw him?
A. I was not at the hospital when this happened. I don't even know if I was there the next day. I'm not sure. This must have been on a Wednesday, so I guess I would have been there on Thursday. But I don't remember the details, no. I don't know if I talked to him about this again. I really don't know.
Q. It looks like it was sent on Monday, December the 12th.
A. I see that.
Q. So you don't recall subsequent to this talking to Joe about this?
A. I don't remember talking to Joe. I talked with Ashley, the other chief resident, but I don't remember what we discussed.
Q. And for the record, who is Ashley?
A. Ashley is the chief resident that he's referring to in the text message.
Q. Is she the chief resident fifth year or chief resident fourth year over a service?
A. She would have been in the fourth year. She

was my year.

Q. Now, in here do you know who he's talking about when he says Kelly and Jack?

A. I do know a Kelly and Jack. I'm assuming it's the night team.

Q. And who are they?

A. Kelly would have been Kelly Brewster. She would have been a second year maybe. And then Jack is another resident.

Q. Okay. Do you know --

A. I'm assuming those are the residents we're talking about. I don't know any other Kelly or Jack.

Q. Do you remember what year Jack was at that time?

A. Jack was a year behind me, so he would have been a third year.

Q. It says: "A code was called on the PA for 3N." I believe that stands for 3 North?

A. Yes.

Q. What is 3 North?

A. 3 North is one of the surgery floors where a large portion of the trauma patients are at.

Q. How big is 3 North? How many patients are we talking about? How many beds are available to help people?

A. I want to say there's 32 or 33 rooms on 3 North.

Q. And Will, is that the same Will Bruch we talked about earlier?

A. Yes.

Q. And he was the one who was also a first-year intern with Joe?

A. Yes.

Q. Now, who is Aaron that's listed?

A. Aaron, he was also a urology intern who was the resident -- or who was the intern for the night float team.

Q. So remind me, I'm sorry, who did you speak to after this text? You said you didn't speak to Joe, but you spoke to others?

MR. WHITFIELD: Object to the form.

BY MR. MORGAN:

Q. You can still answer, Dr. Mahoney.

A. I remember only speaking to Ashley.

Q. And what was that conversation you had with her about?

A. We talked about the situation, but I don't remember what was said.

Q. Do you remember thinking after that conversation that Joe had done something wrong?

A. I remember thinking that -- I guess by this point I must have been making up a -- making my mind up about him that he wasn't a team player, and I remember thinking that this just further exemplified that.

Q. When you say "not a team player," what do you mean by that?

A. I mean that when you're a part of a team, you try to help each other whenever you can, even if that means staying late and doing a little bit extra just so all the work gets done and the patients get taken care of. And there were times I do recall that we would be in our afternoon sessions and I would ask about things, and Joe would say he didn't know or it wasn't his patient.

Q. I'm going to go back to Exhibit Number 1 here. If you can read number 2, this indicates that you did talk to Joe about it. Do you see that?

A. The only recall that I have of talking to him was in that text message. But I mean we may have talked about it. I don't remember.

Q. So do you think you meant the text message when you were writing this or were you talking about a separate --

A. I don't know. I don't remember talking to

him in person, so I only remember the text message. Could I have talked to him in person? Yes. I just don't remember.

Q. And then you say here: "He showed no signs of concern for the patient."

Do you see that?

A. Yes.

Q. Is that in the text message? Because I've not seen that in a text message unless you read it differently than I do. I can go back to it if you'd like me to.

A. Sure.

No, I wouldn't say that there was no concern. I mean I would wonder why he was more upset about his confrontation with an intern rather than his patient having coded. But other than that, no, he does not specifically say anything.

Q. Would you agree that an accusation that somebody -- a doctor left knowing their patient was in trouble -- would you not consider that a serious accusation?

A. I would say that that is -- you have to kind of understand our night float system. I would say that if he knew about it and did not return, that would be a poor move on his part as a doctor.

Q. Have you ever heard of other situations like that occurring where doctors have done that or interns or anybody else?

A. I'm sure it's happened, but I can't recall any.

Q. Now, when the codes are called, can you just describe to me what is said over the loud speaker?

A. They would say "code blue" and then "3 North" or whatever floor. They would say the floor, not the specific room number.

Q. So would that mean that it could be any of those, ballpark, 32, 33 beds that are at 3 North?

A. Yes.

Q. And when you -- during this time frame, if you were there and you heard a code for 3 North, what would you do?

A. I would, as would -- what we would do as residents, we would call wherever we were at, call 3 North -- we'd usually have those numbers memorized -- and speak with the unit secretary, ask which room number it was. I remember in a lot of these situations, if we were in the lounge, whoever was sitting closest to the phone would call up there and then yell out: Hey, room 316; does anybody have that? And then if those people -- if that team was

there in the lounge, then they would head up there. If not, usually we would try to text the team member to let them know that their patient was coding.

Q. And if a person has left for the day, like if it comes in an hour after the shift change, it would be the night team's responsibility to respond to the code?

A. Yes.

Q. Do you ever call a resident and say, hey, you need to come back to the hospital?

A. No.

Q. So here part of the issue is you have a code that occurred literally right at shift change?

A. Right.

Q. That could have contributed to the misunderstanding here?

A. It could have, yes.

Q. Let's go back to Exhibit 1 here. In number 3 here you talk about how he wasn't logging cases. Do you see that?

A. Yes.

Q. What does that mean, not logging cases?

A. In order to graduate from a residency program, we have to prove that we've done so many cases, like 1,200 cases. So in order to make sure

that we're keeping up with that, Dr. Earl or whoever the program director is would just monitor, see when the last time you had logged cases, how long it had been, just so you don't fall behind. And in this situation, if an intern -- which usually the interns were bad about it -- but if an intern was not logging cases, then Renee would go to the chief resident to have us deal with the issue.

Q. So this was, is it fair to say, a common occurrence with interns?

A. More common than it should be, yes.

Q. The idea would be Renee comes to you and you go to the resident because you've got a little bit more authority to sort of prod them to get their logging of cases done?

A. Yes.

Q. And so here you said that you later found out that Joe had not logged anything since the day in Renee's office. Do you see that?

A. Yes.

Q. What was the day in Renee's office? Is that when you, Joe, and Renee were there?

A. I don't remember being in the office with Joe and Renee. And I don't -- I really don't know how I would have found out that he had not logged anything

unless Renee had told me.

Q. I was going to ask -- that was my next question. How did you find out he hadn't logged anything?

A. I don't know for sure. Renee was usually the one that gave us that information, though, because she would kind of keep up with it for Dr. Earl. And I might have even asked her. I really don't remember.

Q. Could you check to see if he had logged cases?

A. No.

Q. Is there any sort of deadline to log the cases?

A. I feel like at some point Dr. Earl said you had to have them done within the last two weeks. And I do remember my fourth and fifth years kind of rushing to even log my own cases before a PD meeting. So I think it was generally before the PD meetings. I feel like those were every two weeks.

Q. When you say the "PD meetings," what does that mean?

A. Program director meetings. We would meet with Dr. Earl as a group.

Q. With all the surgery residents?

A. Whoever could come, if you weren't in the

OR, show up and we would meet with Dr. Earl.

Q. And that was every two weeks?

A. I think so. It was either monthly or every two weeks.

Q. And so were the cases from the previous two weeks supposed to have been logged by then? Is that how it worked? Or something different?

A. For the program director meetings, yes. For the interns in this situation, Renee usually did not talk to us about it unless it had been weeks and weeks and they were very far behind. So I don't know how far behind he would have been. But she didn't talk to us about talking to the intern unless they were very far behind.

Q. Is it fair to say Renee had brought other interns to you as well that were behind on their logging?

A. At some point she would have, yes.

Q. So it wasn't just an issue that was solely unique to Joe?

A. No. They probably even talked to me about logging cases.

Q. There's only so many hours in the day.

A. Exactly.

MR. MORGAN: Well, we've been going about an

hour, so let's just take about a five-minute break. I'm kind of jumping around on my outline, too. So let me take some time to cross out some of these things.

THE WITNESS: Okay.

MR. MORGAN: So we'll just adjourn for five or so.

THE WITNESS: Okay.

(A RECESS WAS TAKEN FROM 3:00 P.M. TO 3:11 P.M.)

BY MR. MORGAN:

Q. Dr. Mahoney, are you good?

A. Yes.

Q. Okay. Let's go back on the record here. Do you recall -- let me pull up Exhibit Number 1 again. In regard to number 4 here about nurses who complained about Joe, do you recall that?

A. Yes.

Q. What do you recall about that? Who are those nurses?

A. They were the nurses on 3 North. I just remember standing at the front nurses station and then having a lot of nurses come tell me things about Papin that they didn't like. I don't remember exactly what they said, though.

Q. You wrote a few sentences here. So you have no other independent memory besides what you've written there?

A. Correct. I just remember standing at the nurses station having a lot of -- at least several nurses coming up to me and telling me their issues with Papin, Joe.

Q. Is it fair to say you don't remember any other examples besides what you've listed here?

A. Not that I recall, no.

Q. Anything else you can remember now about another nurse or anything saying anything negative about Dr. Papin?

A. Not that I remember. I just remember the specific instance because there were so many of them.

Q. Have other interns had issues with nurses?

A. I'm sure, yes.

Q. Have you ever had a situation where you've been the chief where an intern was having issues with nurses?

A. I don't remember specific examples. I think the biggest problem was sometimes nurses felt like they weren't being listened to, and so I would address it with a resident. I don't recall it ever becoming more of an issue.

Q. Did you ever talk to Joe about these issues with the nurses?
A. I believe I did, yes.
Q. What did you and Joe discuss?
A. I don't remember what was said. But I would have -- I would have told him what they had said to me, their issues, and that he needed to work on these things with them because they can make our lives more difficult as doctors.
Q. In what way?
A. We expect them to be our eyes and ears because they are on the floor with the patients. They're with them throughout the day. So I expect -- you know, if you have a good relationship with a nurse, she's going to let you know something right away. Sometimes if you have a really good relationship with a nurse, she'll be at the door waiting for you to round. And that's what you hope for.
Q. So if you have a bad relationship with a nurse, they may not come to you immediately regarding patients?
A. Not necessarily come to you immediately but just -- I feel like there's more communication, there's just better rapport with the entire staff.

Like if you have a good relationship with a nurse, they might send you a text message. That's all I mean by that.

Q. But if it's a bad relationship, they wouldn't text you?

A. You probably haven't shared numbers with each other.

Q. You can't remember any other specific examples about other -- either other times besides what you've described here for Joe with conflict with nurses or any other resident in conflict with nurses?

A. Nothing specific, no.

Q. But you believe it's happened before for other residents and you've addressed it and it's worked itself out?

MR. WHITFIELD: Object to the form.

A. Yes.

BY MR. MORGAN:

Q. The nurses here that you are talking about, are these nurses that are on the trauma service?

A. No. They're nurses on 3 North. So they may have trauma patients, but they're also taking care of any of those 32 patients on the floor.

Q. Would these have been nurses that Joe would have worked with during that December time frame or it

could be any time frame that he was there?
A. Any time frame he was there.
Q. Do you remember when this conversation with these nurses occurred?
A. I don't remember when, no. It may have been after the holidays.
Q. And then on number 5 here it talks about how a med student came to you and said that Joe was not seeing patients before rounds. Do you see that?
A. Yes.
Q. Which medical student was that who told you that?
A. I believe it was -- I think his name was Will Crews. We usually had two. I think it was Will Crews.
Q. And did Will Crews come to you -- was this a verbal conversation or text or email?
A. It was a verbal conversation. I don't know that he necessarily came to me. I have kind of debriefings at the end of the month, and I believe it was during one of those debriefings that he told me this.
Q. Are those debriefings, are those like an individual kind of one-on-one thing?
A. I would sit down with both the med students

or whoever the med students were unless they had been problematic.

Q. So do you think this conversation with Will Crews would have been witnessed by other individuals?

A. Yes. Whoever the other med student was.

Q. And do you remember what the other med student said about that allegation?

A. I don't recall, no.

Q. How did Will know that Joe was not seeing patients before his rounds?

A. The med students are also supposed to see rounds kind of as practice to do physical exams and report information to me and the attending. So the med students are usually there at the same time the interns are.

Q. Do they walk side by side, hand in hand, to go see each patient? Or how does it work in the real world?

A. Sometimes they do, sometimes they go see them individually.

Q. So there could be times where, for example, one is starting at one end of the hallway and one on the other end and they're kind of going opposite ways? Does that sometimes happen?

A. It does. On the trauma service the med

students are in charge of the list, so they usually, at least, got with the interns so that they could give the interns the list in the morning.

Q. Did you ever do your own investigation or double checking of Will's claim that Joe wasn't seeing patients?

A. By the time he had told me -- and I don't remember that he had any specific examples. No, I don't remember looking up anything.

Q. I mean you could have looked in the patient's chart to see if he had visited a patient; is that correct?

A. Well, he could leave a note, but it doesn't necessarily mean that he visited the patient.

Q. Was Will's accusation that Joe was there, just not seeing patients, or he just wasn't even there on the grounds yet?

A. From my remembrance, Will was saying that he was not going in and seeing patients and doing full physical exams. That's what I recall.

Q. Does that mean he was there at the hospital, just not doing that, or like he was late, just hadn't shown up to the hospital yet?

A. I just got that he was not going in the patient's room and seeing the patient. Whether he was

there or not, I don't know.
Q. And so you took Will's word for this?
A. Yes. I had no reason to not believe him.
Q. You personally never saw Joe not visit a patient?
A. No.
Q. You personally had no basis to question that Joe had not seen a patient?
A. I'm sorry. Say that again.
Q. You personally had no personal observation of anything that would lead you to suspect Joe had not seen a patient prior to rounds?
A. Correct. Until the sacral patient.
Q. And that's the ulcer patient?
A. Yes.
Q. Now, on the ulcer patient, do you think he did not see the patient or he did not correctly diagnose the patient?
A. I don't know what he did with the patient. I just know that he told me there was no wound. I don't know if he actually looked or not.
Q. But do you believe he actually went into the room and saw that patient?
A. I don't know.
Q. Earlier we were talking about your -- the

rule that you have about wanting to check the patient's backside. Do you recall that?

A. Yes.

Q. I'd like to get a little more in depth into that comment. When you say "check the backside," what does that mean? Literally walk me through what you would expect somebody to do.

A. I would expect them to go into the room, do a physical exam, you know, assess their mental status, look in their eyes, mouth, you know, head to toe. And because it's difficult to move a 200-, 300-pound patient, we can't always rotate them over on their side to look at their back and then their butt area, which is more prone to these sacral wounds. So when I told them to look at their backside, that meant do your full normal physical exam that you do every day and then have somebody help you rotate the patient on their side to look at their back for any wounds.

Q. And when you're looking at the back, is that just lift them up, look, and then place them back down?

A. Usually, yes, you look, feel. If you see something, kind of touch it to see if it feels soft.

Q. Okay. Are you supposed to do those types of touching tests? I'm trying to figure out where is

that line where you're saying, okay, that's a sufficient examination of the backside?

A. Usually just laying eyes on it will tell you if they have a wound there or not because there will be a discoloration or marking on the skin.

Q. How did you -- how did you express what you wanted the residents to do to them? I know you testified that you said to check their backsides, but did you go to this level of detail that we were just discussing?

A. I don't recall. I just said look for their -- I would have said: Look at their back for wounds. I don't think I went into great detail of how to do a physical exam. I would expect them to know that already.

Q. I believe you testified earlier that you had some experience prior to this time frame with decubitus ulcers; is that accurate? If you could, explain what was your background with them?

A. I was getting a fellowship in the critical care unit, surgery critical care. And so when patients lay on their backs for prolonged periods of time, due to the pressure of the bed, they can get sacral wounds. It's not -- it's unfortunate but not an uncommon problem in medicine.

Q. Are there times when those wounds just happen regardless of what treatment you do?
A. Yes.
Q. And you can do everything in the book, but they'll sometimes just happen?
A. Yes.
Q. Now, during this time frame would you have seen this patient?
A. Yes.
Q. Would you have helped lift him up or seen the backside?
A. Only if the interns told me that they saw something, then I would look at it so I could make a better assessment of what kind of wound it was.
Q. When you're walking into a patient's room, like this patient, would you look at their chart before walking in?
A. Not typically, no. Not unless the resident had some concerns or if I walked into the patient's room and -- what we call the eyeball test -- they don't pass the eyeball test, then I would go look in their chart because something is going on.
Q. So if nobody had told you anything about the patient and you walked in, walk me through what you would be doing for a patient like this, this ulcer

patient.

A. So we typically talk about the patient either before walking around or outside the patient's room. Then we as a team would walk into the room. I would assess anything that I had been alerted to. If the patient is verbal, talk to the patient, ask them if they're having any pain. And then we walk out.

Q. For a person who has a wound, do you know what the term "staging the wound" is?

A. Yes.

Q. What does that mean?

A. Staging the wound is when we essentially assign a stage based on the depth of the wound.

Q. And who is responsible for staging the wound and making that call?

A. Typically it's either -- it depends on how much of the wound you can see. But wound care sometimes can stage it or the physician.

Q. When you say "wound care," what do you mean?

A. A wound care nurse.

Q. And what is a wound care nurse?

A. A wound care nurse is someone who specifically sees a patient just for wounds, sacral wounds, ostomy, anything.

Q. And correct me if I'm wrong, but the wound

care nurse will be requested to consult a patient by physicians?

A. Or occasionally the nurses. If the nurses during bathing have noticed a wound on the patient's backside, they'll go ahead and initiate a consult.

Q. So a nurse or a doctor can initiate it?

A. Yes.

Q. So is it fair to say that the nurses and the doctors rely upon the wound care nurses to review and assess these wounds?

A. Typically when I rely on the wound care nurse is if we can do any type of enzymatic debridements, meaning applying dressings or different types of creams, then that's when I rely on them. They make their recommendations, and then the nurses will carry out the wound care orders.

Q. Are there ever times when you review -- do you review what the wound care team states in the charts?

A. Yes.

Q. And do you typically follow their assessment and their treatment options?

A. I do. I always like to look at the wound myself, though, so I have an idea of what I think needs to be done. Because as a surgeon, I'm usually

the one that makes the decision to -- or I am the one that would make the decision, hey, this needs a debridement in the operating room.

Q. What is a debridement?

A. Debridement means taking away, cutting away, getting rid of dead tissue, necrotic tissue.

Q. Have there been times where you've overruled, for lack of a better term, the wound care team's assessment and treatment options?

A. No, not usually. We work pretty well together.

Q. I'm going to show you -- I'm going to start walking through some of these medical records here. This is the medical record for November the 15th of 2016. And here it looks like, if you can read it -- I know it's a little small -- but it looks like Dr. Robertson initiated a wound care consult. Do you see that?

A. Yes.

(EXHIBIT 6 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. Who is Dr. Robertson?

A. She was a trauma ICU doctor.

Q. Was she an actual -- she wasn't a resident?

She was a doctor-doctor?

A. She was an attending, yes.

Q. And so this would have been mid November, obviously, even before Joe would have come onto the trauma service?

A. Correct.

Q. And it looks like here the wound care nurse, who is Kelly Pennock, made some recommendations here for treatment. Do these look to be standard types of treatment for this?

MR. WHITFIELD: Object to the form.

A. I mean it looks like standard wound care orders. But it would depend on the type of wound.

BY MR. MORGAN:

Q. Do you know what the Pressure Ulcer Prevention Program is?

A. Yes.

Q. What is it?

A. It's a series of steps, guidelines to follow to help prevent pressure ulcers, things such as rotating the patient, essentially decreasing the time that bony prominences, as we call it, are touching the surface of the bed.

Q. Would it be fair to say that these recommendations are in line with that Pressure Ulcer

Prevention Program?
A. Yes.
Q. And it says here in the bottom, it says: "Monitor and notify MD/NP and WOCN of any changes." Do you see that?
A. Yes.
Q. What does that mean?
A. To monitor and let the doctor or nurse practitioner -- I'm not sure of WOCN, I'm guessing that's wound care nurse -- of any changes.
Q. When it says "monitor and notify," who was supposed to be monitoring and notifying?
A. The nurses and the trauma team.
Q. And that would be the trauma team from the interns all the way up through chief resident?
A. Yes.
Q. Would that also include the attending physician?
A. Yes. Working through the hierarchy, I would have let the attending know.
Q. And when it says "notify MD," who does that -- I know that stands for doctor. But I mean who specifically does that mean?
A. To me that means any doctor.
Q. Any of the team doctors?

A. Yes.
Q. I'm going to scroll down to here. This starts here, a record of December the 9th of 2016. So would you have been on the trauma service in November or would you have been somewhere else yourself?
A. I don't remember.
(EXHIBIT 7 WAS MARKED FOR IDENTIFICATION.)
BY MR. MORGAN:
Q. Were you on the same kind of month rotation or different?
A. It changed every year. Some months we would rotate. Sometimes we would do back-to-back months. But I don't recall. I feel like as a fourth year, I probably would have been back to back, but I don't recall what months I was on the trauma service besides December.
Q. And here it looks like another in-patient consult to wound care was given by Dr. Robertson on December the 8th. Do you see that right here? (Indicating.)
A. Yes.
Q. And then down here a little bit lower, this would have been -- -- do you know Kisha Dyse? Do you remember her?

A. I remember her. I wouldn't probably be able to recognize her if I saw her, though. I remember the name.

Q. And it looks like here that she assessed an unstageable pressure ulcer to the sacrum. Do you remember that?

A. Yes.

Q. What does that mean?

A. That there is a pressure ulcer on his sacrum, which is part of his anatomy, and it's unstageable because she is not able to tell the depth of it.

Q. Is this a common occurrence?

A. To get a pressure ulcer?

Q. To get an unstageable pressure ulcer like this? Do other patients have this come up?

A. Yes.

Q. And what's the normal treatment for those?

A. It varies, but usually they start -- the wound care nurse will see them and make recommendations such as the MEDIHONEY or SANTYL, some sort of enzyme and the dressing change, and then we monitor.

Q. Down here at the bottom there's some other recommendations here. Do these look like the normal,

typical recommendations for this kind of wound?
A. There's a lot of different recommendations. But yes, that could be something that's done.
Q. I mean do you look at that record and look at this and say, oh, my gosh, those recommendations there at the bottom are wrong?
A. No.
Q. So then at this point, so on December 9th, this would have been in this patient's chart; correct?
A. Yes.
Q. And so any member of the team, from the first-year interns up through you and up through the attending physician, could see this document?
A. Yes.
Q. So you testified earlier that you didn't know and Joe didn't tell you that there was a wound; correct?
A. Correct.
Q. But this had been in the notes since December the 9th. Do you agree with that?
A. Yes.
Q. Do you think you should have checked the file at some point or checked the chart when you were rounding on the patients?
A. It was not my habit to check every patient's

chart because, like I said, we had so many patients. In between seeing new patients and being in the operating room, I did not have the time to check every chart. So I relied on the residents to give me new information and keep me updated on the patients.

Q. You would have been rounding with other individuals each day and seen this patient each day, at least during the regular work week?

A. We rounded as a team, yes.

Q. Right. So I mean every day you would have rounded as a team and seen this patient?

A. We would go in the room and lay eyes on the patient, yes.

Q. When you say "the team," does that include the attending physician every day, too?

A. Yes. We usually -- the patient is usually seen in the morning three times: first by the intern, then by the entire resident team, and then the team with the attending.

Q. So most days you would have seen this patient twice?

A. Yes.

Q. Do attendings typically check the charts prior to consulting with the patients each morning and rounding?

A. Not typically. Not on patients that are on the floor like this.

Q. I'm only going off of experiences I've had. My dad had heart failure a few years ago. I spent six weeks almost every day in the hospital. And I remember the rounds coming by in the morning, starting with one person and then an hour or so later there would be more people than I could count walking into the room. But typically they'd be looking at a file. Is there something similar that you all are looking at for the patients or no?

A. We have a trauma list that has every trauma patient on it. For trauma it would have the patient, their injuries, the consult teams. And then the med students and interns would update with anything new such as, you know, the patient's weight-bearing status for physical therapy or anything like that. And that's what we walked around with. These charts are all on the computer.

And I'll correct myself. I don't know what the attendings did because I was not an attending. So I don't know if they were looking at the chart or not.

Q. This will be the next exhibit. I'm going to start here at the bottom. Now, this looks like a note that was entered by Dr. Papin. Do you see that?

A. Yes.

(EXHIBIT 8 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. This was on December the 12th of 2016. When an intern inputs a note into the system, it has to be also signed by an attending physician; is that correct?

A. Yes.

Q. Basically it's kind of a supervision, right, on the resident?

A. Right.

Q. So when Dr. Papin enters these notes, it then, I would imagine, probably sends some sort of either email or some sort of notification to the attending physician to review it and state whether they agree or not with it?

A. Yes.

Q. Like on this note here, Dr. -- is it Kutcher? Is that how you say it?

A. Yes.

Q. He reviewed Dr. Papin's note and agreed with it. Do you see that?

A. Uh-huh, yes.

Q. Who is Dr. Kutcher? I know he's a trauma

care surgeon here. Just background, is he a very experienced doctor? What's his kind of background?

A. I don't know his specific background. I enjoyed working with Dr. Kutcher because I thought he was very knowledgeable and I learned a lot from him.

Q. Is it fair to say when these attestations by the attending physician occurred, this would have been after the rounds in the morning?

A. Yes, it would have had to have been.

Q. Because you're sort of affirming what the resident has seen and then what you saw with your own eyes when you walked into the room?

A. Yes.

Q. I'll pull up the next exhibit here. These are mostly in date order here. I'll go down a little bit here because this one is again from Dr. Papin on December the 13th. Do you see this?

A. Uh-huh (positive response).

(EXHIBIT 9 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. And here the note from Dr. Kutcher is a little bit different. I'm going to read it. It says, quote:

"I personally elicited a

history from and examined this patient on rounds on December the 13th, 2016, and agree with the findings and plan as documented in the linked provider's note."

Do you see that?

A. Yes.

Q. So here Dr. Kutcher is saying he personally examined this patient; he wasn't just taking somebody's word for it. Is that accurate?

A. Sure, yes.

Q. And so were you ever in the room when Dr. Kutcher would do his own physical examination?

A. I have been, yes.

Q. Were there times where you would examine the backside for certain patients that needed that done? Would the physical examination get to that level?

A. Not to that level, no. Not unless it was indicated that there was a wound. And usually the attending would not look at it unless I brought it to their attention and said, you know, the patient has a wound, I think we need to take him to the operating room.

Q. Now, all of this information that's kind of

here that I'm highlighting a little bit, this would have been information that Dr. Papin would be pulling in?

A. Yes. And then -- where is his physical exam?

Q. I'm just sort of scrolling.

A. AAO3, that's his physical exam.

Q. That would be Dr. Papin's physical exam or is that the attending's physical exam?

A. Dr. Papin's.

Q. And it looks like in each of these notes there's also a section that talks about the wound care, which would be the most recent wound care recommendations from the wound care nurse?

A. Uh-huh (positive response).

Q. Is that correct?

A. Yes. It looks like he copied and pasted their recommendations into his note.

Q. Is that normal?

A. Every resident does things differently. It's not abnormal.

Q. Have you seen other residents do that as well?

A. Yes.

Q. I mean if you saw that for another resident,

would you call them out and say, hey, you shouldn't be doing that?

A. No. If I saw this particular note, though, I would say I see wound care recommendations but nothing in your physical exam regarding a wound.

Q. Is that something that normally would be in the physical exam section?

A. Yes, if there is a wound.

Q. Would it say I flipped over and examined them and nothing there? Or it wouldn't say that normally?

A. Personally, if I do that, I would write it in my documentation, yes.

Q. And during this time when you're the chief resident, how often are you entering notes like this into the system?

A. I did not. As a chief I did not have to write daily progress notes.

Q. Do you know if you wrote any note for this patient?

A. I don't recall unless it was a -- the notes I usually write for patients would be not what's called a daily progress note but kind of a plan of care, this has acutely happened and this is what we're going to do about it. If the patient coded and I was

there for the code, I would document that in the chart. I don't remember if I documented on this patient or not.

Q. Is it fair to say if you did, it would be in the records?

A. It should be, yes.

Q. I'm going to attach the next exhibit here. This is the one from December the 14th here with Dr. Papin and it looks like Dr. Kutcher again.

A. Yes.

(EXHIBIT 10 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. The next day he wrote the same thing, that he also elicited a history from and examined this patient. Do you see that?

A. Yes. We have dot phrases, and that's why it says the same thing.

Q. What do you mean "dot phrases"? What does that mean?

A. We can create an attestation note. And this is me personally now. When I'm signing a resident's note, I can hit dot and an attestation, and it will pull up the phrase that I want used.

Q. So kind of a copy and paste of previous

language used?
A. Yes, it is.
Q. Standard language, whatever you want to call it?
A. Yes. It's the same -- whatever wording we want, we create a dot phrase, and then we can use it in our notes.
Q. I would certainly hope, though, that the note would be truthful, like Dr. Kutcher did actually examine this patient; right?
A. Yes.
Q. I'll pull up the next exhibit here from December the 15th. This one looks -- let me scroll up a little bit there where the progress notes start here on December the 15th by Dr. Papin, again signed by Dr. Kutcher. But this one looks a little bit different than the one we saw yesterday. This one just says: "I agree with the findings and plan as documented in the linked resident's note."
Do you see that?
A. Uh-huh (positive response).
(EXHIBIT 11 WAS MARKED
FOR IDENTIFICATION.)
BY MR. MORGAN:
Q. Do you agree that's a little bit different

than the one we were looking at the last two days where it said Dr. Kutcher personally elicited a history as well as examined that patient?

A. Yes, that's different.

Q. So do you know back then at this time was there that kind of stock language you could use or did you have to type in what you wanted to actually write, fully type it out?

A. I don't know about the attendings because I never had to attest notes for residents because they wouldn't assign those to me. When I would write notes, I had my own dot phrases that I could use. So I would think that their attendings did as well, but I can't speak for Dr. Kutcher.

Q. So you had your own dot phrases even back then four years ago?

A. Yes.

Q. And how does it work in real life? Is it something you just have memorized and you know to type it out or you hit like a shortcut link on the keyboard and it pops up?

A. So, for example, if I want to write a -- if I'm writing an attestation now on a resident's note, I have previously written one that says something similar to what Dr. Kutcher is saying. I sign a name,

which for me is MMATTEST. And so when I read the patient's note at the end of the day, I hit the attestation button and then I put dot MMATTEST, and it pops up whatever I had previously written so that I don't have to retype it every time.

Q. Almost like the computer sort of remembers what your previous typing had been?

A. Yeah. It's like a clipboard essentially that's permanently stored.

Q. Got it. And is that something that you create for your own personal kind of profile yourself or it's just a normal thing that the hospital has, a clipboard for all the physicians?

A. There are -- we use Epic. There are Epic-generated phrases. And then we can make our own.

Q. I'm going to mark the next exhibit here -- I'll skip over one and go to two days later, which would be December the 17th here. Do you see that note here entered December the 17th?

A. Yes.

(EXHIBIT 12 WAS MARKED
FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. Now, this one was cosigned by Dr. Batson. Do you know who Dr. Batson is?

A. Yes.
Q. Who is Dr. Batson?
A. She's another trauma/critical care, acute care surgeon that's an attending.
Q. Experienced attending physician?
A. Uh-huh, yes.
Q. And so she writes -- she goes on top of Joe's note here and says that she also saw [redacted] today and she agrees with the resident's note. Do you see that?
A. Yes.
Q. When you're doing these attestations, you just kind of quickly summarize and look through the note that the resident has written? How long does it take to do these attestations?
A. It takes a good while. It takes me a good while. I can't speak for Dr. Batson and Dr. Kutcher. But the way I do it is we round in the morning. I make notes specifically for the things that we're addressing that day. A lot of the residents will forward the note from the previous day so you'll see the same wording, same physical exams unfortunately. So I will look through the notes, make sure that they have addressed the topics that we discussed for that day, and then, if something is blaringly wrong, I will

fix it. And then in my attestation, even if they have said it below, I put what we discussed during rounds. That's how I do it.

Q. Do you have any insight as to how Dr. Batson or Dr. Kutcher did theirs?

A. No, I do not.

Q. We're attaching the next exhibit. This is the one from December the 18th, again signed by Dr. Batson. She says:

"I saw [redacted] with the resident. We discussed the plan. I agree with the resident's note."

So when it says "we discussed the plan," that would be what you were sort of describing a minute ago, the sort of plan of treatment and care that would be provided to the patient?

A. Yes. The plan for that day typically is what that means.

(EXHIBIT 13 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. Earlier we were talking about there was another resident named Will Bruch. Do you remember that?

A. Yes.
Q. Was there also another individual named Will Bruch, B-R-U-C-H?
A. I believe it was just Will Bruch. I'm not sure of his last name. I don't recall two different people, though.
Q. How do you think he spelled his last name?
A. I want to say it was B-R-U-C-H, but I don't remember.
Q. Would he have seen this patient during this time as well?
A. He could have. Typically the residents saw their patients, the same patient every day. And then anybody that was new, they divvied them up.
Q. So for the first years typically you're not doubling up on the same patient?
A. No.
Q. Now, what about like weekends when you rotate? Would that be a time when one intern may see somebody else's patient?
A. Yes.
Q. So here if Dr. Papin was assigned this patient, Will Bruch may have seen him on the weekends?
A. Yes.
Q. And we have the next day here, December

19th, 2016. Again, Dr. Batson also would have seen the patient with Dr. Papin; correct?

A. Yes.

(EXHIBIT 14 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. And you would have been there for both of them, the first round as well as the round with the attending?

A. Yes.

Q. Okay. Here's the note for December 20th, again signed by Dr. Batson. A little bit different but similar language:

"I saw [redacted] with the resident on 12/20. We discussed the plan during rounds. I agree with the resident's note."

So again, the attending would have seen this patient?

A. Yes.

(EXHIBIT 15 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. I'm going to show you the next one here.

This is for December 21st there. Here Dr. Batson says: "Late entry for 12/21." Do you know what that would mean?

(EXHIBIT 16 WAS MARKED FOR IDENTIFICATION.)

A. It looks like she attested on 12/22.

BY MR. MORGAN:

Q. Which was the next day?

A. Which is the next day.

Q. Could it just be that she said, hey, this is a late entry for the day before because she just, for whatever reason, could not get to the attestations that day?

A. That's how I read that, yes.

Q. I would imagine that's maybe not a normal thing but not an abnormal thing to occur?

A. Huh-uh (negative response).

Q. Okay. I'm marking the next exhibit. This is for December 22nd, 2016, again with Dr. Papin and Dr. Batson signing on it, where she again saw Mr. Newsome with Joe as well as with you and others; correct?

A. Yes.

(EXHIBIT 17 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. Now, this one I wanted to point out the date of service that's right here, that would be the time that you're actually seeing the patient; correct?

A. No. That was usually when the note is started.

Q. So if it started here and then looks like filed -- it says date of service, 7:51 a.m. and filed 7:55.

A. Right. It looks like he started the note at 7:51 and then four minutes later signed it.

Q. So by 7:51 that morning you would have done the rounds?

A. Not necessarily, no. The residents could start their notes prior to rounding.

Q. But by this point in time Dr. Papin would have seen this patient on that day?

A. I would assume so, yes.

Q. Now, the next exhibit -- this is also on December 22nd, and it looks to be a couple of hours later. Do you see that?

A. Yes.

(EXHIBIT 18 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. And this was a note entered by Kisha Dyse who was the wound care nurse that we were talking about earlier; is that correct?

A. Yes.

Q. Now, it says here this consult was ordered by Dr. Robertson again.

A. Well, that -- I haven't seen a note from Dr. Robertson in here. So the nurses on the floor, since they bathe the patients, they're usually the first ones to see these sacral wounds. That's why I have the residents every week turn the patient over so that we are actively involved. So because of that, the nurses have been given the -- I don't know about the right -- but the opportunity to place orders for wound care. So, you know, a nurse could have seen this wound and then placed a wound care consult order under Dr. Robertson's name.

Q. That's what I was going to ask. I was going to ask you those same questions. I hadn't seen Dr. Robertson's notes or attestations, so could it be just that whenever you -- I would assume you go on the computer program somewhere specifically to order a wound care consult?

A. Yes. Typically the way this works is Dr. Robertson may have been the one that admitted this

patient initially, so her name is put as the admitting attending, and then they all rotate every week. But when orders like wound care -- when the nurse places a wound care order, it goes under Dr. Robertson's name because she was the initial admitting attending even though she had not seen the patient since that first night.

Q. I want to go back to the one we were just looking at a second ago. This was the one with Dr. Papin. Now, here it says kind of something new. It says "febrile overnight." Do you see that?

A. Uh-huh (positive response).

Q. What does that mean?

A. It means the patient had a fever.

Q. If you could, kind of just -- this first sentence here, could you sort of put this into normal layman's terms of what this means in the note?

A. The NAEON means no acute events overnight. And then he says: "Febrile overnight." So I would call that an acute event. But the patient had a fever overnight. Whoever was notified then ordered a urinalysis, a urine culture, and a respiratory culture. BAL is respiratory.

Q. And what are those items?

A. They're specimens that we take the blood,

urine, and then sputum. And then we send it to Microlab so that they are able to test for any bacteria. And typically if the patient has a fever, we get the culture, start them on antibiotics, and then wait for the cultures to return, and then tailor the antibiotics specific for the cultures.

Q. How long does it take for those cultures to return.

A. Usually within five days we have the final cultures. But the patient has been on antibiotics the entire time.

Q. So this would have been a note entered by Dr. Papin that morning. So obviously the culture results wouldn't have been known at that point in time. They had just been taken.

A. There may have been a preliminary but obviously not final.

Q. When you say "preliminary," what does that mean?

A. Preliminary means that -- every day they will check the cultures. And if something new has grown, they'll update it in the Epic chart, in the medical record chart. So usually the first day you might see a gram stain result saying gram-positive cocci, which is just the type of bacteria. And then

by day 5 you should have the actual bacteria name as well as the sensitivities for which antibiotics will treat that appropriately.

Q. Are there times where nothing is growing for that first day and it's hard to tell what it is?

A. If the patient doesn't have an infection, usually you can typically not see anything. Blood cultures and sputum cultures, I would say within 24 hours you usually have something there. But it's very basic and it doesn't change our care plan.

When he says -- can I look at that note again?

Q. Sure. (Complying.)

A. Okay. I believe this patient was nonverbal, so I don't know how they would deny shortness of breath or chest pain.

Q. There was the note from Dr. Kutcher where he said he personally elicited history from the patient. Do you recall that?

A. I'm confused. This says [redacted]

Q. It does.

A. But at the top is says [redacted]

Q. Yeah. I don't know why that is because I believe [redacted] is the patient.

A. Yeah. Okay.

MR. MORGAN: Tommy, do you know why that is?

MR. WHITFIELD: Actually I do. I didn't know if you wanted me to chime in or not.

MR. MORGAN: Sure.

MR. WHITFIELD: As a gunshot wound, he was checked in under an alias name so that way the other people couldn't come and find him and finish the job.

THE WITNESS: I just wanted to make sure we were looking at the right documentation. Because that person was nonverbal, so he couldn't have denied shortness of breath or chest pain.

BY MR. MORGAN:

Q. You're saying [redacted] was?

A. Right. I don't remember ever being able to communicate with him.

Q. So is Dr. Kutcher's note incorrect earlier when he said he personally elicited testimony from -- or history from the patient?

A. I'm not sure if that's what he said. I just want to make sure we're talking about the right patient.

Q. Do you remember this decubitus ulcer patient that ultimately turned surgical?

A. Yes.

Q. So your memory is that this patient was

nonverbal?

A. Yes.

Q. I'm just going to go back to one of the previous notes here. This is the December 14th note here where you see Dr. Kutcher saying: "I personally elicited a history from and examined this patient."

I take that to mean he talked to the patient. Do you take that a different way?

A. I take that as he got the history from Joe, from the provider's note.

Q. And what do you base that off of?

A. That's how I'm reading it.

Q. But I mean it's going to be based on something because it doesn't say he elicited a history from the resident or from Joe.

A. The way I attest notes is I say that I personally got the history from the resident. But it doesn't necessarily have to say that. That's who is giving you the story. We don't always talk to the patient and get a full history. And then he examined this patient. That's how I'm reading this, that he's agreeing with the resident's note.

Q. When you say that this patient, you believe, was nonverbal, does that just mean he couldn't speak back?

A. Right.
Q. Could he shake his head yes or no?
A. I don't remember that.
MR. WHITFIELD: Hey, Ryan?
MR. MORGAN: Yes?
MR. WHITFIELD: I don't want to like slow down your train. But if you get to a spot in about 10 minutes or so, a good stopping point, I need to make a phone call. So whenever you get to a good point, I'd like to take a break.
MR. MORGAN: Okay. Yeah. Give me like five minutes.
MR. WHITFIELD: Sure.
BY MR. MORGAN:
Q. I want to go back to -- this is the Kisha Dyse December 22nd note. So she came back and did another wound care assessment on December 22nd; correct?
A. Yes.
Q. And she again reassessed it as an unstageable pressure ulcer. Do you see that?
A. Yes.
Q. So what happens -- so this note gets entered in by Kisha. Does the team just review the note? What happens once this note goes in?

A. What should happen is when the resident gets there in the morning -- when the intern gets there in the morning, he looks through notes to collect anything from wound care, orthopedic surgery, any other consulting services, gets their recommendations, puts it in his note, and then tells us about it at rounds.

Q. So would you have been told about this at rounds?

A. I should have been, yes.

Q. Do you think you were?

A. No.

Q. Why do you not think that?

A. My first knowledge of the patient's wound was when he sent me a text message on his last day in the service saying that wound care recommendations were in for an early sacral wound on Mr. [redacted].

MR. MORGAN: Let's go ahead and take that break. Tommy, how long do you need for your phone call?

MR. WHITFIELD: I'm not sure. I just got a note I have a client that something happened out at the med center that I need to check in on.

MR. MORGAN: Okay.

MR. WHITFIELD: I'll call back in as quick

as I can.

MR. MORGAN: Okay. We'll take at least five minutes.

(A RECESS WAS TAKEN FROM 4:10 P.M. TO 4:20 P.M.)

BY MR. MORGAN:

Q. Going back to the December 22nd Kisha Dyse note again, when a wound care nurse is reviewing these types of wounds, you would agree with me that they have the training and the knowledge to know whether a wound is infected or not?

A. Yes.

Q. So if it was infected, we would certainly hope that it would be listed in the note?

A. That may be difficult to ascertain if they can't see below that black eschar stuff.

Q. But if they had a question or if they thought there was some sort of infection, I would imagine they would bring that to somebody's attention?

A. I would imagine so, yes.

Q. That's a fairly -- that sets off alarm bells when you have an infection; is that fair to say?

A. Yes.

Q. So here there's no -- at least how I'm reading it, I don't see any noting or discussion of

there being any possible infection; correct?
A. I don't see her using that.
Q. I think I asked this earlier. I just don't remember what your answer was. Did you know that Kisha Dyse and the wound care team were doing these consults with this patient?
A. Not at the time, no.
Q. It wasn't until after this time when the surgery occurred?
A. No. After Joe told me that wound care recommendations were in for this early wound, I went and looked in the chart and realized that there were multiple wound care notes or more than one.
Q. I think I have that text here, the next exhibit. If looks like a text message between you and Joe. And it says here: "Wound care recommended continuing SANTYL for [redacted]'s early sacral decub."
Do you see that? Did I say that right, "decub"? Is that how you say it?
A. Yes.
(EXHIBIT 19 WAS MARKED
FOR IDENTIFICATION.)
BY MR. MORGAN:
Q. That was the text message you were just kind of referring to?

A. Yes.

Q. Do you remember when you got this did you immediately go run to the chart and look or was it more of a, hey, let me go back and look when I get a chance?

A. No. Because it's a typical -- you know, like we said, it's not uncommon for patients to get sacral wounds. So he had been telling me that there wasn't one. And then when he said there's an early sacral decubitus, I said: Okay, now the patient has one, we'll look at it on rounds tomorrow. It's not an emergency situation to go look at it right now.

Q. Okay. So you got this text. Is it fair to say you didn't drop what you were doing and go review Mr. [redacted]?

A. Right. I made a note to look at it the next day on rounds.

Q. And then he has another text about updates on patients. And then you responded that, hey, come to the lounge, and it looks like you'd be running the afternoon list. Is that fair to say?

A. Right, yes.

Q. This would be the kind of end-of-the-shift review we were talking about earlier, which for some patients may be real easy, quick, nothing new to

update?

A. Right.

Q. Do you remember talking about this patient here, Mr. [redacted] on this afternoon list? Because you would have known by this point that wound care had been called; correct?

A. Correct.

Q. Do you remember thinking, oh, we need to go check that now or we'll just check in the morning?

A. No. Like I said, because he said early sacral decub, at this point I thought: Okay, the patient now has a wound and we'll look at it tomorrow. It wasn't -- it didn't set off alarm bells at the time to me.

Q. When did it set off alarm bells to you?

A. When I looked at the sacral wound the next day on rounds and actually saw the wound in person.

Q. Were you the one who peeled back the scab or was that somebody else?

A. I don't recall. I may have. I don't really remember. I typically do pick at wounds when I see them, but I don't remember exactly what I did with his wound, no.

Q. I'm going to share the next -- this is kind of a continuation of the text message here where it

looks like the next morning on December 23rd you texted back to Joe asking: "Who is the one with the wound, [redacted] or [redacted]?" Do you see that?

A. Yes.

(EXHIBIT 20 WAS MARKED FOR IDENTIFICATION.)

BY MR. MORGAN:

Q. And then he responded back that it was Newsome and whatnot. And you didn't respond to this text message, it looks like; correct?

A. Correct.

Q. Four days later you were texting him about meeting in a different patient's room, it looks like?

A. When I sent that text, I distinctly remember -- at this point I had seen the patient's wound and something didn't seem right to me. And I wanted to make sure that I was understanding what he had said, and I didn't want to try and point fingers at this point.

Q. So at 9:07 that morning you had not yet seen this patient?

A. No. I had seen the patient by this point.

Q. But you were asking which one -- you were asking, between two patients, which one it was. Do you see my point?

A. Right. I was -- alarm bells had gone off. At this point was when I started to feel that he had lied to me. So I sent him the text just to make sure that he had actually talked about Mr. [redacted]

Q. Well, he had because he had sent you the text the day before.

A. Right.

Q. And then he responded right away to you on this morning of December 23rd?

A. Right. That text from me on December 23rd was: Something is not right here, I think he's been lying to me.

Q. Well, it doesn't say that in the text, does it?

A. No. Because I'm not going to come out and say that, start pointing fingers immediately. I had to investigate.

Q. Is it fair to say when you read your text the morning of December 23rd, it looks like you're asking him to confirm which patient it is, that you're not even sure which patient has the wound?

A. That's what it looks like, but I remember -- I remember seeing the patient that morning and sending this text message. I know that's odd to say, but I do.

Q. And how do you remember that?
A. Just because I remember seeing the wound and being shocked at how progressed it was and knowing that he had told me there was not a wound. And I didn't know -- you know, I knew that this patient was going to need some surgical debridement. So I was upset that the patient had a wound that size at that point and I did not know about it.
Q. I want to ask you what you just said a second ago, that he told you -- Joe told you that this patient did not have a wound. Did he physically say, verbally say, this person doesn't have a wound? Or did he just not mention it? Because those are two different things.
A. So on Mondays, on our turnover Mondays, I would ask them during our rounds if the patient -- does the patient have a backside wound, a sacral wound, and he would say no. So in my mind the patient did not have a wound until the 22nd when he said there was an early wound. And then when I saw it on the 23rd, I realized that this was a lot worse than I thought it was.
Q. If you could, let's walk through that 23rd when you're saying you realized it was way worse than what you thought it was. If you could, let's do the

chronology when you first came in in the morning. Who did you speak to, what did you do to see this wound for what it was?

A. I don't remember the chronology of what I did. But you have moments when you're a doctor that stick with you. And the moment I turned this patient over and I remember seeing how large it was has stuck with me. So I don't remember what I did when I came in that morning or anything like that.

Q. Who else was with you in the room when you turned the patient over?

A. I do not know.

Q. Would there be a note of you doing that, turning the patient over and making that assessment?

A. Probably not from me. I don't recall, though.

Q. Do you recall if there was anybody else in the room with you?

A. There would have had to have been because I can't turn a patient that size by myself.

Q. You just don't remember specifically who it was?

A. No, I don't.

Q. Do you think it would have been the round where it's with the attending physician or the first

round without the attending physician?
A. It would have been the first round. Because I had already made a note to look at it. So my plan was to look at it during the round and then be able to report it to our attending.
Q. This will be attached as the next exhibit. This is the note for the morning of December the 23rd. It looks like this was entered by Ronnie Brown. Do you know who that is?
A. Yes.
Q. Who is Ronnie Brown?
A. He's a nurse practitioner on the trauma service.
(EXHIBIT 21 WAS MARKED
FOR IDENTIFICATION.)
BY MR. MORGAN:
Q. Why did he enter this note and not another resident?
A. Occasionally the nurse practitioner -- because there's so many patients, we do have nurse practitioners that have random days where they come in and help see patients. And they will help divvy up the patients on the floor in the morning with the interns.
Q. Could it also be just because -- I know

during the holidays there's times where residents get a week off for Christmas and then the other half get the week off for New Year's?

A. No. They have their own schedule when they come in. There was two of them, I believe. And it was a very random schedule. I never really knew if we were going to have a nurse practitioner unless I looked at the schedule. It wasn't a day-to-day thing. But if they were there, they would see some of the patients and split them up with the interns.

Q. Now, this note signed by Dr. Carroll, who is Dr. Carroll?

A. He's another trauma/critical care surgeon, kind of the equivalent of Dr. Kutcher and Dr. Batson.

Q. Okay. Looking at this note, does this jog your memory at all of who may have been with you in the room when you saw this wound?

A. Keith may have been.

Q. And that's the nurse practitioner?

A. Yes.

Q. I notice it's Ronnie, but it sounds like he goes by his middle name, Keith?

A. Keith, yeah.

Q. Do you remember Dr. Carroll being there at all?

A. Not when I -- I don't recall him being there when I first saw the patient, no.

Q. Do you remember discussing the patient with Dr. Carroll?

A. I would have discussed it, but I don't remember discussing what we said.

Q. On that 23rd you say you have a very vivid memory of turning the patient over and seeing the wound. Do you have any other memories from that day of anything else regarding this patient?

A. I remember being angry that he -- and shocked that he had a wound when I did not -- I had been told for the past two Mondays that there was no wound there. And when I saw it, just based on experience, I felt that this did not happen overnight and this was not an early sacral wound as Joe had said in his text the previous day. So I was frustrated and upset with Joe, you know. The text I sent to him was -- I really just wanted to say: What have you done? But, you know, I wanted to make sure that we were talking about the right patient, you know. I wouldn't say I was trying to give him an out, but maybe I was trying to give him an out for lying -- or what I felt was lying to me.

Q. What do you mean by "giving him an out"?

I'm not following. I'm sorry.

A. To come clean. You know, like I said earlier, occasionally interns will get nervous about certain situations and spout out yes or no to questions even though that may be inaccurate. So I feel like there's good teaching moments when an intern does that because you can go back and say, you know: This does not look like it's what you said it was, do you want to repaint this? Or let's talk about it.

So I was trying to give him an opportunity to say: Oh, no, sorry, it was, I guess, [redacted], just to give him --

Q. That would have been lying even more; right? If he had said [redacted], that would have been lying completely?

A. Well, I feel like he had lied completely anyway. But I was trying to give him an opportunity to say, you know -- be some kind of wound or something besides what he said.

Q. But the day before this he had said in that December 22nd text: "[redacted]s early sacral decubitus wound."

A. Right. I may not be understanding what you're trying to ask me.

Q. I guess I'm trying to understand is when

you're saying you were trying to give him an out, what that means when you're asking him which patient it was.

A. Rather than saying: Joe, I feel like you've been lying to me for two weeks about this patient, I phrased it as a question for him to say, you know: It is [redacted], I'm sorry, I have not been looking at the patient's backside, he obviously does have a wound.

Q. Okay. So when you noticed this wound on the morning of the 23rd, what was your -- what was your course of action? What did you do next?

A. I don't remember the exact steps. I know after I saw it, I went in the hallway and -- you know, just random memories that you hold onto. And I remember texting him, sending that text at the nurses station.

But then we would have finished our rounds. And I guess we were rounding with Dr. Carroll that day. I would have told Dr. Carroll about it.

Q. Do you remember discussing with anybody else, any of the other nurses, nurse practitioners, anybody else who had been treating that patient whether they had noticed it?

A. I may have, but I don't recall.

Q. I mean as part of the wound care team's

recommendation, it was a daily changing of the dressings; correct?

A. Right.

Q. And typically that would have been something done by nurses; correct?

A. Correct.

Q. And so the nurses would have seen this wound daily?

A. Yes. But they had different nurses. So I may have asked the nurse that day if she knew about it. But typically the nurses are different day and night and day to day. So I wouldn't have been able to ask every single nurse.

Q. If a nurse saw a wound growing -- and that's kind of what we have here; right? We've seen from November through December 22nd now this wound getting larger. Would you agree with that?

A. Yes.

Q. When nurses are seeing this daily, don't they have some responsibility to also call this to a doctor's attention?

A. I can't assign responsibility to the four nurses. I don't know that they've had that kind of training to --

Q. What about the wound care --

A. To my knowledge, what they're responsible for is if they see something, that they can either tell us or get wound care involved, which is what happened with this patient, wound care got involved.

Q. Now, wound care -- which we've gone through a few different wound care notes showing a progression. Doesn't wound care have some responsibility if they see it getting worse to also bring it to a doctor's attention?

A. I can't speak for them either. But the documentation going into the chart, I would feel, is them alerting us.

Q. Has there ever been a time with the wound care team where one of the wound care nurses has come to you or another doctor that you've personally witnessed where they said: Hey, we've got a bad one, kind of alarm bells-type thing going off that we were talking about earlier?

A. I have that relationship with my wound care nurses here, but I don't recall that necessarily being the typical protocol at UMC.

Q. Do you remember if Ms. Dyse, Nurse Dyse, was an experienced wound care nurse?

A. I don't know.

Q. But I think you said your testimony was you

may have spoken to some of the other nurses about it that day, but you don't specifically recall?

A. I don't recall who I talked to besides the team and Dr. Carroll. And I don't recall exactly what we said to each other.

Q. But in your mind, you blame Joe?

A. In my mind I did not -- I did not blame Joe for the wound, but I blamed him for not alerting me to it sooner because that was the expectation set forth from the beginning, that they would look at the patient's backside on Mondays and let me know if there was something there so then I could look at it and determine the course of action.

Q. You don't think any other nurse, any other resident, any other attending physician has any responsibility for that?

MR. WHITFIELD: Object to the form.

BY MR. MORGAN:

Q. You can still answer.

A. I can't speak to other people's responsibility. In my opinion, everybody in the hospital is responsible for patient care. But I put that task specifically on the interns because -- since I could not see everybody's backside myself, I was relying on them to look. So to me it was their

responsibility to look as part of our team because that was what -- that was the duty that they had been given.

Q. Do you think Dr. Kutcher's work on this patient met the standard of care?

A. His standard of care was met because -- I feel like because he was given the information that we gave to him. His care plan was based on the information that we were giving to him.

Q. What about for Dr. Batson?

A. Same thing.

Q. What about for you?

A. Same thing. I would not go look at a patient's backside unless the interns told me that there was an issue.

Q. Do you think Joe met the standard of care?

A. No, I do not.

Q. Why?

A. Because he was told as part of his duties as an intern to look at the patient's backside. I don't know if he did or not, but he certainly did not give me accurate information.

Q. How do you know he didn't give you accurate information?

A. Because the patient had a wound even dating

back to, that we know of, on December 9th, based on the wound care notes. Because after I looked at the note, I looked into the patient's chart and saw that wound care had seen the patient on the 9th. So when I asked him that Monday, I guess it was the 12th, this is the patient, is there a wound, and he said no, then to me that is inaccurate and lying.

Q. So even though -- and I'll go back and I'll attach it here as a previous exhibit. This is the November 15th, 2016 note by the first wound care nurse for this wound, which was ordered by somebody; right? Somebody noticed this wound to order this; correct?

MR. WHITFIELD: Object to the form.

A. Uh-huh (positive response).

BY MR. MORGAN:

Q. Would you agree with me that there has to be a person who has to order a wound care consult?

A. Somebody had to order a wound care consult, yes. I don't see any pictures to what degree. It looks like: "Consult received for patient that is high risk for pressure ulcer development."

So I don't know that the patient actually had an ulcer at that point but that he was high risk. So nursing wanted to get them involved.

Q. Surely here on December 9th by Kisha Dyse,

the wound care nurse, we did have pictures?
A. Yes.
Q. And we do see that there's a wound?
A. Yes.
Q. So you testified a moment ago that wound care nurses tell the doctors what's going on by submitting these notes into the charts; correct?
A. Yes.
Q. So is it fair to say that during this time period, you didn't review the chart, and it doesn't look like any attending physicians reviewed the chart either. Otherwise someone would have noticed this wound?
A. Right. It is -- as spelled out, at the beginning of the month, it's the intern's job to look through the charts to read any consult notes, any consult recommendations. And then we're alerted to that. We don't typically -- I didn't typically and the attending that I know of -- I can't speak for the attending. But I did not typically go into the chart unless I was alerted to something or something didn't seem right to me.
Q. So it's a first-year intern's fault for this?
A. It's not the first-year intern's fault that

the patient got a wound. It's his fault for not telling me when I asked him: Does this patient have a wound? It's his fault for not saying: Yes, this patient has a wound.

Q. Do you ask it like that? I guess I'm still a little confused about that interplay. Are you asking him for each patient does this person have a wound or is it kind of an open question?

A. Not usually for each patient. And it's still my practice today -- except I made it turnover Tuesdays -- that if a patient has been there for an extended period of time, they are at high risk to get a sacral wound. So those patients, I expect them to turn over on Monday. And on rounds that day I will say: Is there a wound on the backside?

Q. Do you know for this patient was there any sort of ICARE report or incident report that was ever filled out for this patient?

A. I don't recall. But there should have been one placed afterward when we discovered this wound.

Q. What do you mean there should have been one?

A. Because there is a delay in care on this patient.

Q. But to your knowledge --

A. I don't know if there was one or not.

Q. Do you recall any sort of subsequent investigation or discussion with anybody at the hospital about this patient after this kind of December 23rd time frame?

A. I investigated by looking at the patient's chart just to see what he had written in his daily progress notes. And that's when I saw the December 9th note. I don't really recall any other discussions except, you know, talking to Dr. Carroll and then when I went to Dr. Earl and Renee.

Q. Which was then what led to that January 10th email we looked at in the beginning?

A. Right.

Q. So you discussed this patient with Dr. Earl?

A. Yes.

Q. What do you recall about that conversation?

A. I don't remember exactly what we said. I'm sure I told him that the patient had a sacral wound that was advanced, that we had turnover Mondays and that I had asked Joe if there was a wound, and he said no. And that was not a type of wound that would develop overnight. In my opinion, he had that wound previously. And then it turns out, looking at the chart, that even on the 9th he had something there.

Q. The same one that the nurses would have seen

every day?
A. Right. And my concern -- the concern wasn't the wound when I went to Dr. Earl; it was that Joe had lied about it to me.
Q. Why would he lie to you? If it was there and he saw it, why would he lie to you when it was in the chart?
A. I can't answer that.
Q. When you turned over the patient on December 23rd -- and you said you had that vivid memory of remembering that -- was the wound infected at that point?
A. You can't really tell if it's infection per se as far as like pus or anything like that. Whenever I see that black eschar, just based on experience, I'm going to assume that there's an infection because that makes a person a higher risk to set up for infection.
Q. What happened to this patient? Did he undergo surgery?
A. He did undergo surgery. He underwent several, if I remember correctly. He went through an initial debridement that day and then eventually got what's called a diverting ostomy.
Q. And what is that?
A. That's where we -- because the wound is so

bad, we feel it won't heal appropriately since it's near the rectum and will get stool into the wound and will deter wound healing. So we give them a colostomy where they poop in a bag to divert the route of stool away from the wound.

Q. I think I asked you this, and I apologize. Sorry. It's getting late in the day. Do you have a specific memory of a discussion about this patient with Dr. Carroll?

A. I don't remember. I don't have a specific memory. But if he was the attending that day, I would have told him about it.

Q. And you recall the discussion later with Dr. Earl about it but just that one time?

A. It may have been more than once. I just know that when we came back from holidays, I felt the need to let him know that I felt Joe had lied about the patient. But I don't recall what was said or how many times we discussed it.

Q. What is a mortality and morbidity report?

A. It is -- we call it our M&M. And it's a conference that we held on Wednesdays to discuss morbidities, which is adverse events or possibly preventable events, and morbidities is when we discuss patients that have died.

Q. Was this patient ever discussed at an M&M conference?
A. I don't remember. I believe he was.
Q. When would that have been?
A. The next year in January or February. We typically would -- any patient that's presented at M&M was done within a couple of months.
Q. And I imagine there would be records of some type for those M&M conferences?
A. Right.
Q. Like there would be a list or there would be charts and things that were presented to individuals?
A. Yes.
Q. Who sits in on those M&M conferences?
A. The attendings and all the residents are there, and we discuss the patients.
Q. So that's a pretty big group?
A. Uh-huh, yes.
Q. And so you do or you do not recall if this patient was discussed at that M&M event?
A. I don't recall, no.
Q. I'm going to go back to the -- this is the hearing transcript. This is on page 56 where you're talking about this patient here. And one of the examiners had asked you about, quote:

"By anything, you mean -- I mean everybody knew that this patient had a wound, the nurses, or did nobody even know that he had a wound?"

Do you see that question?

A. Yes.

Q. And you responded with just that you did not know he had a wound; correct?

A. Correct.

Q. But you did not respond to that question that nurses would have known about the wound; is that accurate?

A. Right. Because I don't know what nurses knew or didn't know.

Q. But you agreed and admitted earlier that these nurses would know because they're the ones changing the dressings daily?

A. Right. But I can't speak for them to say that they knew about this wound.

Q. But you could have told that to this committee?

A. I only wanted to speak for myself.

Q. But you also expressed to this committee other events that had been told to you that you had

not personally witnessed; correct?
A. Say that again.
Q. You had expressed to this committee and testified to this committee about events that were told to you that you did not see firsthand?
A. Correct.
Q. So why did you feel like you didn't have to disclose that the nurses would have seen it?
A. Because I did not know if a nurse had seen it or not. I may be confused.
Q. I mean --
A. Let me read what she said.
Q. Sure.
A. (Document review.) It sounds like I was just speaking for myself, that I didn't know that he had a wound.
Q. Other than the email that we looked at at the beginning, the January 10th email, did you lodge any other sort of formal complaint or anything against Dr. Papin?
A. I believe I only took it to Dr. Earl and Renee.
Q. Prior to testifying at the hearing, did you review any documentation, the records or reports or anything like that?

A. I don't recall. I'm not sure.
Q. Do you remember if you discussed the patient, Mr. [redacted], with the wound care nurse, Kisha Dyse?
A. I don't recall that. I don't believe I did, no.
Q. I think you discussed it -- you said you discussed it with Dr. Earl. But I think you might have also discussed it with Renee Greene?
A. I don't know that I necessarily discussed the wound. I just discussed the situation and that Joe had lied to me about it.
Q. And what was her response? Just put it in writing?
A. Yes. I don't recall exactly what she said, but she obviously told me to put it in writing.
Q. Anything you can recall about that conversation or her response to you in regard to these allegations against Joe?
A. No. It's been too long.
Q. Now, do you recall during the hearing you testifying that a male med student had told you about how a female med student felt uncomfortable around Joe?
A. Only what I've read in the transcript.

Q. Who was that male med student?
A. Will Crews.
Q. And do you know who the female med student was?
A. I don't remember her name. She was the other med student along with Will.
Q. Do you remember when Will told you that?
A. I don't recall. Only what's in the transcript.
Q. But do you recall -- if you're kind of using the wound patient as sort of ground zero, right, December 23ish, was it before this time, was it after that time?
A. I don't remember. It may have been at that debriefing meeting that we have at the end of the month. I really don't remember. Because with the holidays, everybody gets kind of spread out.
Q. Now, when you heard that, what was your response?
A. I don't remember.
Q. Do you remember thinking: Oh, my gosh, this is very serious and I need to report this to somebody?
A. I feel like I wanted to go talk to her about it, but I don't remember. It's been so long ago.
Q. Do you think you did go to talk to her about

it or you don't think you did?
A. I don't remember.
Q. You would agree with me that allegations of harassment are serious things?
A. Yes.
Q. And that if there are allegations of harassment, they should be reported to Human Resources?
A. Yes.
Q. And you agree with me that when you heard this allegation, you did not report it to Human Resources?
A. I did not go to Human Resources.
Q. So you agree that once you heard this allegation, you did not take it to Human Resources?
MR. WHITFIELD: Object to the form.
BY MR. MORGAN:
Q. You can still answer.
A. I did not go to Human Resources.
Q. Will Crews, didn't he also tell you that Joe would be gone for periods of time?
A. That's what was in the documents that I've read. I don't recall our conversation.
Q. I was going to say what do you remember about that and what did you personally witness?

A. It's been so long, I don't remember.
Q. Do you have any memory or whatnot that Joe would just disappear during the day?
A. I remember there being times where I didn't know where he was. Because every once in a while I would go to the third-floor resident workroom, and he would not be in there. But that didn't -- you know, he could be anywhere. He could be in the ER, he could be in a patient's room.
Q. But is it fair to say, during his work with UMC, you personally were not of the belief or had some suspicion that he was just not working?
A. Only what I heard. I never could prove that he was not there.
Q. Did you do anything to double check whether that was true or not?
A. No, not that I recall.
Q. Did you ever like check his parking garage card?
A. No.
Q. Can you check -- could you go onto the Epic system or another one of those computer systems and kind of type in Papin's name and see all the notes and everything that he's been doing throughout the day?
A. I could go into an individual's patient's

chart and see if he wrote a note. But I don't know how I could just look specifically for what Joe did.

Q. Did you ask anybody else there when you heard this allegation from Will Crews if other people felt Joe was just disappearing for periods of time?

A. I seem to remember asking the other intern, but I don't recall all the conversation.

Q. And who was that other intern?

A. Will Bruch.

Q. Other than the numbering system that we were talking about before where you would counsel Joe on what you thought were inappropriate or unprofessional behavior traits, did you ever give Joe any other feedback besides that about his performance?

A. I don't recall specifically. But it is my habit to give feedback, positive and negative, to residents. So I imagine I did.

Q. Do you have any specific recollections of any discussions with Joe about that?

A. Not specific, no.

Q. Did Joe do anything good?

A. I can't recall anything specific. I know that I gave him some positive feedback, so he must have at some point. But I don't recall specific instances, no.

MR. MORGAN: I might be just about done here. Let's just take a few minutes and I'll go through my outline here.

MR. WHITFIELD: All right.

(A RECESS WAS TAKEN FROM 5:02 P.M. TO 5:07 P.M.)

BY MR. MORGAN:

Q. Dr. Mahoney, do you text with Dr. Earl?

A. Yes.

Q. Did you ever text with Dr. Earl about Papin?

A. I don't know. I don't remember.

Q. Do you still have those texts with Dr. Earl?

A. I believe I only have texts from 2018 because I had to get a new phone.

Q. But if we requested those, you could look and just verify one way or the other how far back it goes?

A. Yes.

Q. How did you come to find out that you were going to testify at the appeals hearing?

A. I believe Dr. Earl told me.

Q. And what did he tell you about it?

A. That there was going to be like an ethics committee there from the hospital staff that I needed to tell my side of the story and what I noticed while

he was on the service.
Q. Did you and he discuss what specific topics to discuss?
A. I don't recall. I'm sure he asked me to discuss the sacral decubitus patient.
Q. Did you have any specific memory of that conversation beforehand about what he wanted you to testify about?
A. No, I don't.
Q. Did you talk to anybody else about that hearing prior to testifying?
A. I don't recall, no.
Q. Did you go back and talk to any of the nurses or med students or other residents or anything like that?
A. I believe I may have talked to Ashley Griffin because she was at that same meeting. But I don't remember what we talked about.
Q. I was about to ask what did you and Ashley talk about?
A. I don't remember. It's been so long.
Q. Do you think you went back and looked at any of the records or any of your text messages with Joe before you testified?
A. I know I went back and looked at some of our

text messages, and I made screenshots of those. I feel like it was mostly about the sacral wound because to me that was the biggest issue. To me the critical issue was I felt he had lied about this patient. So I did make some screenshots of our text messages.

Q. Did you go back and review your January 10th email?

A. I don't recall.

Q. Do you know did -- in preparing for that hearing, did Dr. Earl or Renee or anybody else give you any sort of documentation to review or outline or anything like that?

A. I don't believe so, no.

Q. Was it just a verbal discussion with Dr. Earl?

A. From what I remember, yes.

Q. Do you remember talking to anybody else besides Dr. Earl and Renee about Dr. Papin kind of between December 23rd and the hearing date?

A. I don't believe so. I mean Dr. Griffin was in my class, and she had worked with him. So that's why we had discussed it. But I don't recall talking to anybody else, no.

Q. The M&M meetings we talked about, remind me when do those occur? You said once a month?

A. Every week, Wednesday mornings.
Q. Oh, sorry. Every week, Wednesday mornings. Okay.
So is there like a schedule or an agenda that is either presented like on a screen or passed out of the cases to be covered?
A. I don't recall the format that we did it that year. I was in charge of it my fifth year. I did change around the format a little bit, but I would just go back and look at things that had been reported. Every week the patient -- or the chief of the service is supposed to turn in an M&M list, and I would get those. I would go through those lists and then pick patients to discuss. But I can't remember how we did it that year.
Q. I'm just going to make up an example here. If a chief lists five cases one week but you decide to only discuss three, what happens to the other two? Is there still like an investigation that's done or it's just not discussed at all?
A. M&M is a teaching tool. It's not necessarily a go back and, you know, look and see every patient. So we would pick patients that we felt we had a good learning opportunity from and then discuss those patients. So it wasn't a risk

management-type meeting. It was purely educational.

Q. Do you know if this patient situation with [redacted] was reported to risk management?

A. I did not report it, but I think -- I believe it was, yes.

Q. Do you know who reported it?

A. I don't know.

Q. Why do you think it was reported?

A. When I told Dr. Earl about it -- I mean before I even went to Dr. Earl, I felt like this was a critical issue, and mostly just because of the lying. And that's why I needed to talk to him about it. And I believe it wasn't so much the wound that was the problem but it was that we had a provider taking care of patients in the hospital that neglected to give information. So I think that -- not that the patient had a wound that was presented to HR, but it was his actions.

Q. Why didn't you bring this situation to risk management?

A. I don't know. But as a resident, we went to our program director about things -- about any problems we had.

Q. If you saw some --

A. I may have not even known to go to risk

management at the time. That's something I've certainly learned as an attending, but I'm not sure that I knew to do that as a resident. To me it was to go to my boss, who was Dr. Earl.

Q. And do you know is there a document or some sort of form or process that has to be started to turn that into risk management?

A. I don't know the steps for UMC, no.

Q. What about for the M&M? Is it just the chief resident list?

A. Again, that's separate from risk management. That's an educational conference. But the chief residents would make up a list and submit it to me and Dr. Earl. And then when I was in charge of the M&M conference, I would go through and pick the cases.

Q. When you say the "chief resident," is this the fifth-year chief resident over everything?

A. Whoever the highest-level resident is, yes.

Q. So in a situation like this with this patient, how would that chief resident know to put Patient [redacted] on the list?

A. Because it's a sacral wound that we would want to report. You know, because sacral wounds happen and they can happen, and we sometimes expect them to happen, I wouldn't necessarily say that this

is something that is just, you know, breaking news, an educational topic that we have to discuss at an M&M conference. But, you know, because it is a wound, then we would have reported it, at least on our M&M list, and submitted it.

Q. But I guess I'm still a little confused of how the chief resident, who may not have provided any care to this patient so they may not even know the situation was happening, how does it get on the list? Is it something you have to tell them? Somebody else?

A. I would have -- as the chief, I would have put it on the M&M list and said [redacted], MRN number, sacral wound, and then said -- you know, it was more of an M&M topic to me because it required an operation.

Q. Where is this M&M list? Is it like a physical list you write on or is it like a computer internal thing?

A. Usually it's something we keep up with on our notes, and then we do like an Excel or Word document and then submit it.

Q. So then all the chiefs -- like you were the chief on the trauma team there. You would do your list, other people would do their list, and then turn it in to the main chief resident?

A. Right. Or whoever was in charge of the M&M conference. And I think Dr. Earl would get it as well.

Q. So for this patient, if there was an M&M conference -- I think you said you thought there was -- there should be some sort of record somewhere that started that process?

A. Correct.

Q. And then when it's presented to the group, are there records that are shown or is it just a verbal discussion?

A. Typically a resident will kind of research the patient, look through the documentation, give the timeline of things that occurred. If there was an operation, what the operation was. And then we would go into up-to-date, current care plans or ways to treat wounds or whatever the morbidity is of the current data on it.

Q. So are there notes and records kept of those M&M conferences?

A. I don't know that they're kept. It's just what's submitted every week. I don't think that they're actually kept in a file or anything, though.

Q. Like if I requested all records related to Patient [redacted]e with an M&M conference, do you know

what records, if any, the hospital should have?

A. I don't know that they would have any. It wasn't -- it wasn't seen as a risk management. So I feel like if [redacted] was presented at M&M, it would have been more -- not so much this patient had a sacral wound, because that happens. It would have been could we have caught this sooner so that the patient didn't end up with a separate operation of the diverting ostomy.

Q. Do you remember this patient being discussed at the M&M?

A. I don't remember. I don't recall, no.

Q. Because you're describing it as a teaching moment; right? It's an educational moment?

A. Correct.

Q. So I usually -- I guess what I'm trying to ask is: Do you remember what the teaching moment was for this patient? If you don't remember, you don't remember. But that's what I'm trying to ask, is what would have been the teaching moment, if you recall what it was, for this patient?

A. In my opinion, I feel that the teaching moment would be to discuss as a team, you know, being honest about reporting patient care, patient physical exams, whatever, and then -- because there was a delay

in care for the sacral wound because he had not been forthcoming with the physical exam information or lied about it, whatever happened.

Q. You're saying "whatever happened." Before you were adamant that he lied.

A. Well, my opinion is he lied about it. So the teaching moment is don't lie about a patient's physical exam.

Q. Earlier you had testified that there had been other instances where interns and others haven't told the truth?

A. Not -- not to this degree to where a patient was affected this much. What I meant by that statement was, you know, interns could be nervous about something and I say: Is the potassium okay today? Yes, when they actually hadn't looked at it. But, you know, gut reaction is they want to give an answer. And then we look at it and they not be. So I say something or they'll go look at it themselves and say: You know what, the potassium was not correct.

But, you know, not to the degree of: I've asked you twice this Monday and the next Monday and you told me that there's nothing. In this particular instance I would say if he said no to me that first Monday and was lying about it, that I would have liked

for him to go say: Oh, I need to go look at this patient because I didn't, seeing the wound that was there, and then come back to me and say: Hey, Meagan, you know, I know I said there wasn't a wound there, but I went and looked. The patient does in fact have a wound. And then we would have been monitoring this on the 12th rather than the 10 days or whatever it was later.

Q. Do you think there was maybe just -- you guys just didn't get -- you crossed wavelengths or something like that and weren't communicating right? Because clearly we saw the notes where Dr. Papin was noting and copying the wound care recommendations.

A. Well, my concern there is that he wasn't actually documenting it in his physical exam. But I do know that I asked him: Is there a wound? And he said: No. Because if he had said yes, there's a wound, I would have looked at it and we wouldn't be in this situation.

Q. What do you mean "we wouldn't be in this situation"?

A. Well, he wouldn't have -- in my opinion, that would not be lying to me about it. And that's the critical issue to me is that he lied to me about it.

Q. And why he was ultimately fired?
A. I don't know why he was fired.
Q. You don't know why he was fired?
A. No, I don't. I don't know what the exact reasons are, no.
Q. When did you first find out that he was fired?
A. I don't remember.
Q. Do you remember learning that, though, at some point?
A. Yes.
Q. Do you remember who told you?
A. Dr. Earl.
Q. What did he say?
A. I don't remember.
Q. Do you remember when it was?
A. No.
Q. It would have been after the appeals hearing or was it before that?
A. I really don't recall. It must have been before.
Q. We've been talking for, what, 3 hours and 20 minutes, give or take? I always like to ask an open-ended question. Anything else you can recall we have not discussed about Dr. Papin --

MR. WHITFIELD: Object to the form.
BY MR. MORGAN:
Q. -- that you remember discussing -- I'll limit it some. Any sort of negative discussions you remember having with any other person regarding Dr. Papin that we have not discussed today?
MR. WHITFIELD: Once again, object to the form. You can answer to the best of your knowledge.
A. I don't even remember what we've discussed today. But no, not that I recall.
MR. MORGAN: That's all I've got.
MR. WHITFIELD: All right. Briefly, just to kind of follow up on a few things.

EXAMINATION

BY MR. WHITFIELD:
Q. I'm going to put up my copy of the letter on the screen so I can manipulate it. But it should be your Exhibit Number 1, if I can make this work.
Can y'all see the January 10th email?
A. Yes.
Q. Okay. My screen went blank except for the email, so I didn't know if it had come through.
So when you wrote this email -- when did you write it?
A. Well, it looks like January 10th.

Q. What year?
A. 2017.
Q. What year is today?
A. 2020.
Q. So we're talking over three years ago?
A. Yes.
Q. Was your memory better of the events back in 2017 or is it better today?
A. 2017. A lot has happened since then.
Q. So if you put it in the letter back then, would you have remembered it back then as happening that way?
A. Yes, I would recall -- I would say that this letter is more accurate than my memory now.
Q. And I want to refer you back to number 2 on the list where you said that you talked to him about it. Do you see that?
A. Let's see. Yes.
Q. So when the code came out right at shift change -- you wrote:

> "When I talked to him about it, he said that he heard the code called overhead as he was leaving the lounge, but that he had signed out so he

left."

Is that what's written?

A. Yeah. That's not the conversation in the text, which it doesn't seem like it was. We must have talked about it separately. Which it sounds like something I would have done. Because, you know, I tried to sit down with the residents and teach and talk. And sometimes I talk too much to them, I guess.

Q. Where is the resident -- where is the lounge?

A. It's on kind of the first floor of the hospital within 30 seconds of the operating rooms.

Q. And from there where is it to 3 North?

A. So our lounge is kind of on one side of the hospital. 3 North is kind of in the middle of the hospital.

Q. But having heard it come off overhead, the phone to call back to 3 North would be in the lounge?

A. Right.

Q. So instead of calling in, apparently he left?

A. Correct. You know, and I don't know when he heard it, if he says in there.

He said he heard the code called overhead. So he was there when the code was called as he was

leaving the lounge.

Q. What would be the normal expectation for an intern if they're in the building and they hear the code called overhead?

A. Because of the night float team, that's probably our worst rotation because it is so busy. Because the night float team is usually very busy, the expectation is that you stay to help to see if they need any help. At least ask: Do you need me to help you with this? And, you know, it being called as a 3 North code and he being on the trauma service and that's where the majority of our trauma patients are, my assumption if I was an intern was that, hey, this may be one of my patients, let me see what I can do.

Q. And in the next little subparagraph of number 2 you write:

> "Getting out of here as fast as possible seemed to be a theme with him throughout the month. During afternoon rounds he would often sigh or get an attitude when I asked him to do something. He used the excuse 'this isn't my patient' as well."

What are you talking about in that package?

A. I don't remember specific instances. I do remember that I would feel frustrated in the afternoon, you know. Because if Will Bruch wasn't there for some reason, if he was down in the ER or whatever seeing a patient, I would try to round the list so that I could get them out of there. It just seemed like he wanted to get out of there. It wasn't his patient. And, you know, if I kept wanting to talk about something, there would be a sigh like, you know, why are you keeping us here any longer?

I remember him -- sometimes he would come into those afternoon sessions in his workout clothes so that he could start working out as soon as he left, which I thought was a little odd, especially since he was still on the clock. But he just seemed like he didn't want to be there, he wanted to get out of there.

Q. So he had showed up to sign out basically, already having changed clothes to go work out?

A. Yes.

Q. And if a call had come in at that point, would he have had to go back to the trauma or whatever in his workout clothes?

A. I would have expected him to just go in his

workout clothes because a patient's life can't wait for him to change back into his scrubs.

Q. And number 3 -- we're back on the logging cases at the beginning of the month. You said Renee would reach out to you and say this resident isn't logging cases?

A. Right.

Q. And then in your recollection here that you wrote on January 10th of '17:

> "He said that he had. And the last time I asked him, he went so far as to say that he had more non-op traumas logged than any of the other residents in his year."

And you later found out he had not logged anything since the day in Renee's office. So that would be the day that Renee told you he had not logged cases?

A. Yes.

Q. So he told you he had?

A. So I would have -- when I asked him a couple more times, just to make sure that he was staying on top of it, mostly so I didn't have to hear Renee talk to me about it again -- I had enough to do. So I

would say: Hey, are you logging your cases? And apparently at one point he said that he had more non-op traumas than anybody, which to me is a very -- that's not just saying yes, I have been. It's going a step further and saying: Yes, actually. So to me it seems like a very -- if he was not logging cases, that is an above-and-beyond exaggeration.

Q. But after him telling you that, did you find out that he had in fact not logged cases?

A. Yes.

Q. And I want to skip down to number 5. This is about the med student, Will Crews; is that correct?

A. Yes.

Q. And in this note that you turned in, you don't mention anything about the female med student that was talked about earlier; is that correct?

A. Right.

Q. And to your knowledge, was it a claim that he was harassing her or that she just felt uncomfortable around him?

A. I believe it was more that she felt uncomfortable around him. You know, I'm trying to pull back from the dregs of my memory. Like I said, I wanted to talk to her. And I feel like, if I remember correctly, I did talk to her. You know, I don't

remember what was said. But it was more that she felt uncomfortable. And Will told me at some point he tried to go down to the ER with both of them, and Joe told him not to. So she was uncomfortable with being around Joe by herself, I guess.

Q. But to be completely fair, nobody has ever made an allegation that Joe Papin said anything to this female med student that sexually harassed her or untoward in any way, to your knowledge?

A. Correct.

Q. It was just her belief she was uncomfortable around him but not that Joe had said anything harassing to her?

A. Correct. I don't recall any of that, no inappropriate touching or anything like that, no.

Q. Now, at the top -- I know I'm jumping around -- but you make the comment that you felt like you were having to give him feedback or talk to him every day.

A. Yes.

Q. And that you had noticed several things by the end of the first week that you felt like he should work on. And he actually thanked you for that input and said he hadn't received any feedback.

A. Okay, yeah, I see that.

Q. Is that your memory of what happened?
A. If that's what it says, yes. I try to be very good about giving feedback sooner rather than later because what's the point in giving it at the very end when they can't work on it?
Q. But then you go into you had to pull him aside several more times just to meet with him even during rounds with the attending. What are you referring to there?
A. I don't remember specific instances. But it sounded like he did something at some point during our rounds with the attending where I felt the need to pull him aside away from rounds to address a certain behavior. And I mean I don't remember certain examples, but I just remember being very frustrated.
Q. All right. Now, when you were under questions by counsel opposite, he showed you a lot of Joe Papin's notes for looking at the decubitus ulcer patient from December 12th through, I believe, December 22nd. Do you recall those?
A. Yes.
Q. And anywhere in those notes that he showed you was there a note from Dr. Papin that he actually did a physical examination and noted his physical examination in the record?

A. No, I did not see the sacral wound mentioned in his physical exam. It seemed to be the same physical exam every day.

Q. But there was nothing noted about the wound, its size, its shape, what he did, how he felt on it, what it looked like?

A. No.

Q. And going back to that point, so wound care came in on December the 9th. That next Monday would have been the 12th. And that was Papin's first note?

A. Uh-huh, yes.

Q. And according to your testimony earlier, he told you there was nothing on the backside?

A. That being a Monday, I would have asked, and he said no.

Q. And he was tasked with that responsibility of checking the backside?

A. Yes, correct.

Q. And as an intern, it's his job to go in and read the notes and the consults that are in the record?

A. Correct.

Q. And it's his job to let you know what's in the notes and consults that are in the record?

A. Correct, more so than anybody else.

Q. And that's the way the team works?
A. Right.
Q. Did he ever bring up with you between December 12th and December 21st that this patient had a wound consult?
A. No.
Q. Did he bring up with you between December 12th and December 21st that this person had a wound on their back?
A. No.
Q. And in fact, there would have been two separate Mondays where he would have been tasked with specifically going and checking the backside of this patient for a wound?
A. Yes. And being asked about it.
Q. And then on December 22nd, as he was basically leaving town to go to the airport, he wrote you a text; is that correct?
A. Correct.
Q. Saying the guy had an early wound?
A. Correct.
Q. I think he actually said [redacted] in the text; is that correct?
A. I believe so, yes.
Q. And that was the very first time he let you

know about the sacral decubitus ulcer?
A. Yes.
Q. And then you saw it the next morning on rounds?
A. Correct.
Q. And he went to surgery that day for the first -- is it debridement?
A. Debridement, yeah.
Q. Debridement? And I believe he asked you about the attending physicians, Dr. Robertson, Dr. Batson, and Dr. Kutcher; is that correct? They were the attendings?
A. Yes.
Q. And it wasn't their responsibility to go in and report back to you on the backside?
A. No.
Q. That was solely the intern's responsibility?
A. Correct.
Q. And with wound care, the wound care nurse placing the note into the record, it was Dr. Papin's responsibility to read the note and inform you of it?
A. Correct
MR. WHITFIELD: I believe that's it.
MR. MORGAN: I have some followup.

MR. WHITFIELD: I thought you might.

EXAMINATION

BY MR. MORGAN:

Q. Dr. Mahoney, so if an intern doesn't say anything to a senior resident or attending physician, you're just never going to check a patient's records ever?

A. If they say -- if they don't say something to me and then I walk in and look at the patient and it's not congruent with what they've told me, then I will go and look in the patient's chart, you know. But to me, in this circumstance, I had asked him pointblank: Does this patient have a wound? And he said: No. So I had no reason to feel that I needed to go look at the patient's backside or look in the patient's chart.

Q. So you're telling me at the University of Mississippi Medical Center, unless a first-year intern tells you or an attending something, you're not going to look at the chart?

A. I do look at the chart for various reasons. I do look at charts, yes, I look at charts.

Q. You're not looking at all the notes?

A. Not necessarily, no.

Q. Who is more responsible for a patient's

care, a first-year intern or a senior resident?

A. I feel that we are all responsible for their care.

Q. Who does the buck stop with?

A. I would say the buck would stop with -- legally the buck stops with the attending, I guess. To me we're all responsible and we all play a role in the care of the patient because there's so many patients. If I had to do it personally, something could be missed. So we break it up with the interns at that level. It's like the Swiss cheese effect. It starts with them, they report things to us or don't report things to us, then it goes through different levels.

Q. But you agree that ultimately the attending physician is responsible for care of patients?

A. Yes. I mean we all are, yes.

Q. When you were asked about the female medical student who felt uncomfortable, Mr. Whitfield was very clear to point out it was not an allegation of harassment; correct?

A. Correct.

Q. But certainly when you hear the words that a male makes a female uncomfortable, do you not take that to mean some sort of sexual sort of issue? Or do

you take it a different way?
A. I think you can make the assumption. But, you know, that wouldn't be appropriate to assume.
Q. So even if a male was making a female uncomfortable and you knew it, don't you agree that would still be a reportable issue to HR?
A. Not necessarily HR.
Q. But here you didn't --
A. I feel like if he had -- if he had, you know, sent her a sexual text or touched her inappropriately, that's something that needs to go to HR. You know, if somebody says they feel uncomfortable, I don't know that that would necessarily need to go to HR.
Q. Well, you felt the need to testify in front of a group of doctors about this; correct?
A. I don't recall testifying about the harassment or uncomfortable.
Q. You didn't mention in the hearing that there was a med student who had come to you discussing she was uncomfortable?
A. I would have to look at the records. I don't remember making those -- I could have.
Q. Is there a code blue team?
A. A code blue team?

Q. Uh-huh (positive response).
A. Yes.
Q. What's the code blue team?
A. A code blue team is a medicine team that responds to codes.
Q. When you say "medicine team," who encompasses that team?
A. Whoever is the on-call medicine team of medical doctors.
Q. How many are on there?
A. I don't know.
Q. Ballpark. Are we talking one, five, in between?
A. More than one, probably less than five. It's whoever the medicine -- the actual medicine team in the hospital, they're called the code team if they're on call.
Q. So during this code that we were discussing earlier that happened, the code blue team would have responded, too; right?
A. They should have, yes.
Q. Now, when Mr. Whitfield started the cross-examination of you, he asked you about, hey, this was over three years ago at this point; right? All these issues. Is that fair to say?

A. Yes.
Q. But it's also fair to say you're not intentionally lying today, are you?
A. No.
Q. You're trying to tell the truth as best you can remember it; right?
A. The best I can remember, yes.
Q. So you may not be able to remember everything, but what you've testified to is true and accurate of what you can remember?
A. As far as I know, yes.
MR. MORGAN: No more questions.
MR. WHITFIELD: All right. Off the record?
MR. MORGAN: Off the record.
(A DISCUSSION WAS HELD OFF THE RECORD.)
COURT REPORTER: I have a question. Mr. Whitfield, do you want a copy of this deposition?
MR. WHITFIELD: Yes. And we would like to read and sign.
COURT REPORTER: Okay.
(THE DEPOSITION OF MEAGAN MAHONEY, MD, WAS CONCLUDED AT 5:43 P.M.)

C E R T I F I C A T E

I do hereby certify that the foregoing proceedings were taken down by me and transcribed using computer-aided transcription and that the foregoing is a true and correct transcript of said proceedings.

I further certify that I am neither of counsel nor of kin to any of the parties, nor am I in anywise interested in the result of said cause.

I further certify that I have earned the certifications awarded by the National Court Reporters Association of RPR,RMR,RDR,CRR,CRC,RSA.

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CERTIFICATE OF WITNESS

PAPIN vs. UMMC, et al. 3:17-CV-763-CWR-FKB

I, MEAGAN MAHONEY, MD, do hereby certify that on this _____ day of _____ 2020 I have read the foregoing transcript and to the best of my knowledge it constitutes a true and accurate transcript of my testimony taken on oral examination on November 18, 2020.

_____
MEAGAN MAHONEY, MD

DATE: _____

_____
WITNESS TO SIGNATURE

CERTIFICATE OF CHANGE

PAPIN vs. UMMC, et al. 3:17-CV-763-CWR-FKB

Under penalty of perjury, I, MEAGAN MAHONEY, MD, declare that I have read the foregoing transcript and hereby swear that my testimony therein was true at the time it was given and is now true and correct, including any corrections and/or amendments listed below:

Subscribed and sworn to before me this _____ day of _____ 20___.

_____
MEAGAN MAHONEY, MD

_____
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